

---

---

# YOUR MEDICAL GROUP

Doctor's Name, M.D.

(Sample only)

---

Dear Patient: Our goal is to provide comfort, convenience, and satisfaction as well as the very best medical care to all our patients. We'd like to know how you feel about our medical services, our patient-handling systems, our physicians and staff members. Your comments will help us evaluate our operations to ensure that we are truly responsive to your needs. Thank you for your help.

---

**PLEASE RATE THE FOLLOWING:**

	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
<b>A. YOUR APPOINTMENT:</b>						
1. Ease of making appointments by phone	5	4	3	2	1	N/A
2. Appointment available within a reasonable amount of time	5	4	3	2	1	N/A
3. Getting care for illness/injury as soon as you wanted it	5	4	3	2	1	N/A
4. Getting after-hours care when you needed it	5	4	3	2	1	N/A
5. The efficiency of the check-in process	5	4	3	2	1	N/A
6. Waiting time in the reception area	5	4	3	2	1	N/A
7. Waiting time in the exam room	5	4	3	2	1	N/A
8. Keeping you informed if your appointment time was delayed	5	4	3	2	1	N/A
9. Ease of getting a referral when you needed one	5	4	3	2	1	N/A
<b>B. OUR STAFF:</b>						
1. The courtesy of the person who took your call	5	4	3	2	1	N/A
2. The friendliness and courtesy of the receptionist	5	4	3	2	1	N/A
3. The caring concern of our nurses/medical assistants	5	4	3	2	1	N/A
4. The helpfulness of the people who assisted you with billing or insurance	5	4	3	2	1	N/A
5. The professionalism of our lab or x-ray staff	5	4	3	2	1	N/A
<b>C. OUR COMMUNICATION WITH YOU:</b>						
1. Your phone calls answered promptly	5	4	3	2	1	N/A
2. Getting advice or help when needed during office hours	5	4	3	2	1	N/A
3. Explanation of your procedure (if applicable)	5	4	3	2	1	N/A
4. Your test results reported in a reasonable amount of time	5	4	3	2	1	N/A
5. Effectiveness of our health information materials	5	4	3	2	1	N/A
6. Our ability to return your calls in a timely manner	5	4	3	2	1	N/A
7. Your ability to contact us after hours	5	4	3	2	1	N/A
8. Your ability to obtain prescription refills by phone	5	4	3	2	1	N/A

---

Form: XXXX    Provider: XX    Site: XX    Specialty: XXX

**PLEASE COMPLETE THE OTHER SIDE** 

	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
<b>D. YOUR VISIT WITH THE PROVIDER: (Doctor, Physician Assistant, Nurse Practitioner)</b>						
1. Willingness to listen carefully to you	5	4	3	2	1	N/A
2. Taking time to answer your questions	5	4	3	2	1	N/A
3. Amount of time spent with you	5	4	3	2	1	N/A
4. Explaining things in a way you could understand	5	4	3	2	1	N/A
5. Instructions regarding medication/follow-up care	5	4	3	2	1	N/A
6. The thoroughness of the examination	5	4	3	2	1	N/A
7. Advice given to you on ways to stay healthy	5	4	3	2	1	N/A
<b>E. OUR FACILITY:</b>						
1. Hours of operation convenient for you	5	4	3	2	1	N/A
2. Overall comfort	5	4	3	2	1	N/A
3. Adequate parking	5	4	3	2	1	N/A
4. Signage and directions easy to follow	5	4	3	2	1	N/A
<b>F. YOUR OVERALL SATISFACTION WITH:</b>						
1. Our practice	5	4	3	2	1	N/A
2. The quality of your medical care	5	4	3	2	1	N/A
3. Overall rating of care from your provider or nurse	5	4	3	2	1	N/A

**WOULD YOU RECOMMEND THE PROVIDER TO OTHERS?**      Yes      1      No      2

**IF NO, PLEASE TELL US WHY:** \_\_\_\_\_

**IF THERE IS ANY WAY WE CAN IMPROVE OUR SERVICES TO YOU, PLEASE TELL US ABOUT IT:**

**SOME INFORMATION ABOUT YOU:**

**GENDER**

Male      1  
Female      2

**YOUR AGE**

Under 18      1  
18-30      2  
31-40      3  
41-50      4  
51-60      5  
Over 60      6

**ARE YOU:**

A new patient      1  
A returning patient      2

***Thanks very much for your help!***