

# PATIENT SATISFACTION SURVEY

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Name : \_\_\_\_\_

*Over the course of your treatment, how satisfied were you with the following items  
(please circle one answer on each line):*

	Very Satisfied	Somewhat Satisfied	Neutral	Dissatisfied	NA
1) Help provided for billing questions?	4	3	2	1	0
2) Getting through to the office by phone?	4	3	2	1	0
3) Length of time on hold?	4	3	2	1	0
4) The courtesy and consideration provided by the office staff?	4	3	2	1	0
5) The ability to schedule a convenient appointment time?	4	3	2	1	0
6) Length of time in waiting room?	4	3	2	1	0
7) The information you were given about your condition and treatment plan?	4	3	2	1	0
8) Your primary therapist/practitioner?	4	3	2	1	0
9) Your overall therapy/care?	4	3	2	1	0
10) Your overall rating of this facility?	4	3	2	1	0
11) How would you describe your condition upon discharge?	Much Improved (4) Unchanged (2)		Improved (3) Worse (1)		
12) Would you return to this facility for future care?	Yes (4)		No (1)		
13) Would you refer a friend or family member to our facility?	Yes (4)		No (1)		

**Primary Therapist's Name:** \_\_\_\_\_

Comments:

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*Thank you for your time and consideration! Your answers will encourage us to improve our services. Our goal is to completely satisfy our clients. Please sign below if you will allow your comments to be included in marketing materials.*

*Signature* \_\_\_\_\_ *Date* \_\_\_\_\_