

DATE _____

**PATIENT SATISFACTION SURVEY
NEW RIVER HEALTH ASSOCIATION**

Below are a number of questions about your **recent office visit**. Please answer each question by checking the box that best indicates your opinion, or if a question doesn't apply to your situation, check "N/A". If the patient is a minor/child or cannot complete the survey, family members may do so for him or her. If you (the patient) have been a patient at our facility before, please answer only about your most **recent visit**. Your answers will help us to improve our services.

Before Your Office Visit	Very Good	Good	Fair	Poor	N/A
How would you rate the: Ease in getting through to the office by phone?					
Courtesy of the staff that took your call?					
Time between making your appointment and day of your visit?					
Clinic hours meet your needs?					
Ease in seeing provider of your choice?					
At the Time of Your Visit:					
How would you rate: The courtesy of the receptionist?					
The registration process (simplicity, speed, etc)?					
The comfort of the waiting area?					
The overall quality of care you received?					
Waiting time from your appt time to the time you saw a provider? _____ just about right _____ a little too long _____ way too long					
The overall quality of care you received from your provider?					
The overall quality of care you received from the nurse?					
The amount of time spent with the provider?					
The explanation of what was done for you? (Tests, diagnosis, treatment)?					
How well were your questions answered?					

Would you recommend our clinic to others? _____ Yes _____ No

Comments? _____

PROVIDER _____