Nephrology & Hypertension MEDICAL ASSOCIATES

PATIENT SATISFACTION SURVEY

PROVIDER NAME: _____

LOCATION WHERE SEEN: _____

Dear Patient:

According to our records, you recently visited our practice. We would appreciate your opinion about our services. Your responses will be kept strictly confidential. You may provide us with your name if you desire to share it.

PLEASE RATE THE FOLLOWING:

	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
A. YOUR APPOINTMENT:						
1. Appointment available within a reasonable amount of time	5	4	3	2	1	N/A
2. Ease of making your appointment	5	4	3	2	1	N/A
3. Efficiency of the check-in process	5	4	3	2	1	N/A
4. Waiting time in the exam room	5	4	3	2	1	N/A
5. Waiting time in the reception area	5	4	3	2	1	N/A
B. OUR COMMUNICATION:						
1. Relevance of our educational materials	5	4	3	2	1	N/A
2. Your ability to contact us after hours	5	4	3	2	1	N/A
3. Your phone calls were answered promptly	5	4	3	2	1	N/A
4. Your test results were reported in a reasonable amount of	5	4	3	2	1	N/A
C. FACILITY / PRACTICE:						
1. Convenient hours of operation	5	4	3	2	1	N/A
2. Easy to follow signage and directions	5	4	3	2	1	N/A
3. Overall comfort	5	4	3	2	1	N/A
4. Parking	5	4	3	2	1	N/A
5. Overall satisfaction with our Practice	5	4	3	2	1	N/A
6. Quality of your medical care you received from us	5	4	3	2	1	N/A
D. YOUR VISIT WITH THE PROVIDER: (Doctor, Nurse Practitioner)						
1. Amount of time provider spent with you	5	4	3	2	1	N/A
2. Instructions given regarding medication/follow-up	5	4	3	2	1	N/A
3. Knew important information about your medical	5	4	3	2	1	N/A
4. Things explained in a way you could understand	5	4	3	2	1	N/A
5. Time taken to listen and answer your questions	5	4	3	2	1	N/A

	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
B. OUR STAFF:						
1. Care and concern of our nurses/medical assistants	5	4	3	2	1	N/A
2. Courtesy of the person who took your call	5	4	3	2	1	N/A
3. Friendliness of the receptionist upon your arrival	5	4	3	2	1	N/A
4. Helpfulness of the staff who assisted you with billing or insurance questions	5	4	3	2	1	N/A

WOULD YOU RECOMMEND OUR PRACTICE TO OTHERS? Yes ▢ No ▢

ADDITIONAL COMMENTS:_____

_____

SOME INFORMATION ABOUT YOU:

GENDER

Male ▢
Female ▢

YOUR AGE

Under 18 ▢
18-30 ▢
31-40 ▢
41-50 ▢
51-60 ▢
Over 60 ▢

ARE YOU:

A new patient ▢
A returning patient ▢

Thanks very much for your help!

Patient's Name (optional) _____

Please return to:
1115 Lexington Ave; Savannah, GA 31404
Or
Fax: (912) 354-7569
Or
Email: Appt@TheKidneyDocs.com