Tri-State Pulmonary Associates, Inc

Patient Satisfaction Survey

Name of the doctor you saw: **Office Location: (Auburn Ave, West Chester, Red Bank**

Your responses will be kept strictly confidential. Thanks for your help.

PLEASE RATE THE FOLLOWING:

	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
A. YOUR APPOINTMENT:						
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. The efficiency of the check-in process	5	4	3	2	1	N/A
5. Waiting time in the reception area	5	4	3	2	1	N/A
6. Waiting time in the exam room	5	4	3	2	1	N/A
7. Keeping you informed if your appointment time was delayed	5	4	3	2	1	N/A
8. Ease of getting a referral when you needed one	5	4	3	2	1	N/A
B. OUR STAFF:						
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
C. OUR COMMUNICATION WITH YOU:						
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

	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
D. YOUR VISIT WITH THE PROVIDER: (Doctor or Physician Assistant)						
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
E. OUR FACILITY:						
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
F. YOUR OVERALL SATISFACTION WITH:						
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	5	4	3	2	1	N/A

WOULD YOU RECOMMEND THE PROVIDER TO OTHERS? Yes No

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 YOUR AGE ARE YOU:

Male	Under 18	A new patient
Female	18-30	A returning patient
	31-40	
	41-50	
	51-60	
	Over 60	

If you would like someone from our office to contact you, please provide your name and a day time telephone number:

Thanks very much for your help!