WESTERN NEUROSURGERY, LTD.
PATIENT SATISFACTION SURVEY

Dear Patient:

We would like to know about your experience with our practice. Your feedback is important to us. Please complete this survey and return it in the enclosed envelope.

Date of Visit: _____ Doctor:_____

Age: Under 21 ……..... ☐ 21-44…… ☐ 45-64…… ☐ 65-74…… ☐

75 or older…… ☐

Please provide feedback on your visit today.

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
The waiting time was acceptable.				
The Doctor was able to help my condition.				
The doctor explains fully what he/she will be doing.				
The doctor takes the time to respond to my medical concerns.				
The doctor clearly explains my medications.				
The doctor is pleasant and approachable.				
The staff is knowledgeable.				
The doctor's secretary is courteous & efficient.				
The staff handles my questions in an acceptable manner.				
The staff handles my billing issues in an acceptable manner.				
The staff or doctor returns my call in a timely manner.				
The receptionist treats me with respect and courtesy.				
The reception area helps me feel at ease.				
The examination room is pleasant.				
My privacy and the privacy of other patients is respected.				
The doctor and staff work together to provide me with quality care.				
I was pleased with the medical treatment that I received.				

Circle the 3 statements above that are most important to you.

_____

Name (optional)

THANK YOU FOR YOUR HELP WITH THIS SURVEY
Please feel free to make comments on the back of this page

COMMENTS: