



Patient Satisfaction Survey

Thank you for taking the time to complete this survey. Your feedback is important to us, as it will help us to improve our service and office operations. All responses will be kept confidential. Please place a check in the box that best fits your answer. If you would like a follow up call or update please feel free to include you name and our Patient Advocate will contact you.

1. **How did you hear about our office?**
 Physician
 Patient / Friend
 Mail/Magazine _____
 Website
 Insurance Company

2. **How long have you been a patient at Adriatica Women's Health?**

3. **What is your Zip Code?**

4. **What is your age?**

5. **How satisfied were you with the Scheduling staff?**
 Extremely Satisfied
 Very Satisfied
 Satisfied
 Very Unssatisfied
 Extremely Unssatisfied

Did you receive the appointment type and/or date and time you requested?
 Yes No

If you are unsatisfied with Scheduling what was the area of concern?

6. **How satisfied were you with the Check In staff?**
 Extremely Satisfied
 Very Satisfied
 Satisfied
 Very Unssatisfied
 Extremely Unssatisfied

If you are unsatisfied with Check In what was the area of concern?

7. **How long did you have to wait in the lobby?**

 Appt Time _____
 Arrival Time _____

8. **How satisfied were you with your Nursing staff?**
 Extremely Satisfied
 Very Satisfied
 Satisfied
 Very Unssatisfied
 Extremely Unssatisfied

If you are unsatisfied with Nursing what was the area of concern?

9. **What Provider are you seeing today? (Circle one)**
 Banks Carter
 Halderman Marley
 Kidd Santamaria
 Fadahunsi Hall

10. **How much time did you spend with the Provider?**

11. **How satisfied were you with your Provider?**
 Extremely Satisfied
 Very Satisfied
 Satisfied
 Very Unssatisfied
 Extremely Unssatisfied

If you are unsatisfied with your Provider what was the area of concern?

12. **Were you satisfied with the overall service you received during your visit today?**
 Yes No

13. **Would you recommend other patients to our office?**
 Yes No

14. **What are the things you liked most about your visit today? (Check all that apply)**
 Location
 Service
 Doctor
 Medical Treatment
 Staff
 All of the above
 Other _____

15. **What are the things you liked least about your visit today? (Check all that apply)**
 Location
 Service
 Doctor
 Medical Treatment
 Staff
 Other _____

16. **Are you familiar with our Patient Online Access service?**
 Yes No
- If so, are you satisfied?**
 Yes No

If no, please indicate why.

Would you like additional information or assistance with navigating through or setting up your POA account from our Patient Advocate? If so please provide a phone number to reach you.

17. **How was your experience with our billing team either today or in the past? Were they pleasant and helpful? Was your issue resolved?**

18. **How could we improve your time in the lobby and/or future visits?**

* Please feel free to use the back of this page for additional comments and/or feedback if needed.