

CENTRAL MASS ALLERGY & ASTHMA CARE

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We value our patients and invite your comments, suggestions, or complaints about the care we provide. By evaluating the strengths and weaknesses of our practice, you will assist us in providing better health care to our patients. Please circle your doctor's name above and write in your approximate appointment date if known _____.

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|--|-----|----|----------|
| 1. Was our staff friendly and courteous? | Yes | No | |
| 2. Are our office hours convenient for you? | Yes | No | |
| 3. Was it easy to make an appointment? | Yes | No | |
| 4. Do we see you on time for your appointments? | Yes | No | |
| 5. Do you feel that enough time was spent with you? | Yes | No | |
| 6. Did your doctor answer all your questions clearly? | Yes | No | Somewhat |
| 7. Did our staff return telephone calls in a timely fashion? | Yes | No | N/A |
| 8. Were your billing questions answered satisfactorily? | Yes | No | N/A |
| 9. Did we meet your expectations? | Yes | No | |
| 10. Are there any areas where we could improve? | Yes | No | |

Please comment further on above questions. Tell us about what we could do better or improve on. We also want to know what you really liked or who did an awesome job:

If you would you like us to contact you about questions or concerns, please include your name and phone number. Name _____ Phone# _____

Please drop off, fax in or mail to our office, Attn: Joan and watch as we continue to improve services for our patients. You can also copy and paste into our general comments email from our website. Thank you for your comments!!