

Medical Finance Resources

PATIENT SATISFACTION SURVEY (DMEPOS Products/Services)

In an effort to continuously monitor and maintain the highest degree of customer satisfaction and service you receive from our Facility, please complete this survey and return to the address listed below. We value your opinion highly!

Date Patient Name *(optional)*

DMEPOS Product/Service Received _____

Please rate your degree of satisfaction on a scale of 1 – 5.
1 indicating **Complete Dissatisfaction** and **5** indicating **Complete Satisfaction**
(Circle your Score; If Not Applicable, Circle “NA”)

- | | | | | | | |
|--|---|---|---|---|---|----|
| 1. Customer Service: | | | | | | |
| Pedorthist | 1 | 2 | 3 | 4 | 5 | NA |
| Facility Personnel | 1 | 2 | 3 | 4 | 5 | NA |
| DMEPOS Product Trainer | 1 | 2 | 3 | 4 | 5 | NA |
| Delivery Driver | 1 | 2 | 3 | 4 | 5 | NA |
| 2. Time Frame for Delivery of Product/Service | 1 | 2 | 3 | 4 | 5 | NA |
| 3. Quality of Product/Service Received | 1 | 2 | 3 | 4 | 5 | NA |
| 4. Product Ease of Use | 1 | 2 | 3 | 4 | 5 | NA |
| 5. Product Set Up | 1 | 2 | 3 | 4 | 5 | NA |
| 6. Training Received on Product Use | 1 | 2 | 3 | 4 | 5 | NA |
| 7. Training Received on Product Care and Maintenance | 1 | 2 | 3 | 4 | 5 | NA |
| 8. Product Safety | 1 | 2 | 3 | 4 | 5 | NA |

Comments: _____

Please Return Completed Survey to:

119 Main Street, South River, NJ 08882 or Fax to 732-390-4722