**COASTAL DIGESTIVE DISEASES, PC**
**Patient Satisfaction Survey**

We would like to know how you feel about the services provided so we can make sure we are meeting your needs. Your responses will be used to improve our services. All responses will be kept confidential and anonymous. Thank you for your time.

**Visit Date:** _____ **Age:** _____

| Please circle how well you think we area doing in these areas: | Great 5 | Good 4 | OK 3 | Fair 2 | Poor 1 |
|---|---|---|---|---|---|
| **Ease of making appointment:** | | | | | |
| Ability to get in to be seen | 5 | 4 | 3 | 2 | 1 |
| Hours Office is open | 5 | 4 | 3 | 2 | 1 |
| Convenience of Office location | 5 | 4 | 3 | 2 | 1 |
| Prompt return on calls | 5 | 4 | 3 | 2 | 1 |
| **Waiting:** | | | | | |
| Time in waiting room | 5 | 4 | 3 | 2 | 1 |
| Time in exam room | 5 | 4 | 3 | 2 | 1 |
| Waiting for test to be performed | 5 | 4 | 3 | 2 | 1 |
| Waiting for test results | 5 | 4 | 3 | 2 | 1 |
| **Staff: Providers** | | | | | |
| Listens to you | 5 | 4 | 3 | 2 | 1 |
| Takes enough time with you | 5 | 4 | 3 | 2 | 1 |
| Explains what you want to know | 5 | 4 | 3 | 2 | 1 |
| Gives you good advice and treatment | 5 | 4 | 3 | 2 | 1 |
| **Medical Assistants** | | | | | |
| Friendly and helpful to you | 5 | 4 | 3 | 2 | 1 |
| Answers your questions | 5 | 4 | 3 | 2 | 1 |
| **Telephone/Check In/Check Out** | | | | | |
| Friendly and helpful to you | 5 | 4 | 3 | 2 | 1 |
| Answers your questions | 5 | 4 | 3 | 2 | 1 |
| **Payment:** | | | | | |
| Explanation of charges | 5 | 4 | 3 | 2 | 1 |
| Collection of payment | 5 | 4 | 3 | 2 | 1 |
| The balance you pay | 5 | 4 | 3 | 2 | 1 |
| **Office:** | | | | | |
| Neat and clean | 5 | 4 | 3 | 2 | 1 |
| Ease of finding where to go | 5 | 4 | 3 | 2 | 1 |
| Comfort and safety if waiting | 5 | 4 | 3 | 2 | 1 |
| Privacy & confidentiality | 5 | 4 | 3 | 2 | 1 |
| | | | | | |
| The likelihood of referring friends and family to us | 5 | 4 | 3 | 2 | 1 |

Suggestions for improvement: _____

Other comments: _____

Thank you for completing this survey!