PATIENT SATISFACTION SURVEY

To better serve our patients, we need your help in letting us know what we did well and, more importantly, what needs improvement. After you complete the survey, please return it to your pain management practice. THANK YOU!

Name (optional): ____ Provider: _________________Date: __________

Comments: ____

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		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1.	**Scheduling Appointments**: My phone call was handled promptly and courteously, and my appointment was made within a reasonable time frame.					
2.	**Office Environment**: The office was conveniently located. It was clean and comfortable, and it had good lighting and temperature.					
3.	**Office Friendliness**: The office staff was professional, courteous, friendly, and helpful.					
4.	**Wait Time**: I waited a reasonable length of time in the reception area and the exam room before seeing my healthcare provider.					
5.	**Level of Trust**: I trust my healthcare provider to make decisions and recommendations that are in my best interest.					
6.	**Helps Patients Understand Their Condition**: My healthcare provider explained my condition and treatment options in a way I could understand.					
7.	**Listens and Answers Questions**: My healthcare provider listens to my concerns and answers my questions.					
8.	**Time Spent with Patient**: I was allowed adequate time with my healthcare provider.					
9.	**Recommend to Friend**: I would recommend my healthcare provider to family/friends.					
10.	**Overall Rating**: I am pleased with the overall quality of care and treatment I received.					