We strive to provide a high level of patient satisfaction. Please help us evaluate our performance by completing this form. This information will help us to understand whether we are meeting your needs.

Date of your last appointment ______________ Physician/C.N.M.______________

Please circle one number on each line to rate your level of satisfaction with our services.

1 = Poor 2= Acceptable 3= Good 4= Excellent

1. Ease of reaching our office on the phone 1 2 3 4
2. Convenience of our office locations 1 2 3 4
3. Length of the wait at the office 1 2 3 4
4. Friendliness of our reception staff & medical assistants 1 2 3 4
5. Helpfulness of our billing office 1 2 3 4
6. Explanation of your condition and treatment 1 2 3 4
7. Time spent with physician/ C.N.M. 1 2 3 4
8. The comfort and cleanliness of our office environment 1 2 3 4

If you have the opportunity will you recommend our office to others? Y N

Comments and/or suggestions:________________________________
____
____

Name (optional):_________________________