

General Complaint Comments

Actions You Would Like to See Taken

Your Name _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____

Email _____

Do you wish to remain anonymous? Yes No

May the Patient Quality Foundation contact you? Yes No

Patient Quality Foundation
PO Box 79396
Corona, CA 92877

Please Take One

Patient Quality Survey



Place
Stamp
Here

PATIENT SATISFACTION SURVEY

Print the FULL name of your Doctor/Therapist _____

Print the ADDRESS of the facility you attended _____

- | | strongly
agree | agree | disagree | strongly
disagree | no
opinion |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. My doctor/therapist was courteous | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. My doctor/therapist understood my problem or condition | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. The explanations my doctor/therapist gave me were helpful | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. The front desk person was courteous | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. I was satisfied with the treatment provided by the doctor/therapist | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. I was satisfied with the treatment provided by the assistants | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. The facility scheduled appointments at convenient times | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. My first visit was scheduled quickly | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. It was easy to schedule follow-up appointments | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. I was seen promptly when I arrived for treatment | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11. The location of the facility was convenient for me | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12. Parking was available for me | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 13. My bills were accurate | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 14. The cost of treatments I received were reasonable | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 15. I would recommend this facility to family or friends | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 16. I would return to this facility for care in the future | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 17. My privacy was respected during my care | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 18. Overall, I was satisfied with my experience here | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

19. Your age: _____ years

20. Your gender: Male Female

21. Choose the BEST description of your problem: Post Operative Chronic Minor Severe Other

22. What did you like BEST about your experience: _____

23. What did you like LEAST about your experience: _____

24. What would you say to someone considering this doctor/therapist or facility?: _____

May the facility use your statement in their literature? _____ May they use your name in their literature? _____

[If you answered yes to both questions above, please complete the rest of this form.]

Name _____ Signature _____ Date _____

Address _____

Email Address _____ Telephone _____