



# Samuel Y. Brown MP, AP, MC Questionnaire

Dear Patient: According to our records, you recently visited **the provider named above.** Please tell us your opinion about the service you received **from this provider.** Your responses will be kept strictly confidential. Thanks for your help.

**PLEASE RATE THE FOLLOWING:**

	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
<b>A. YOUR APPOINTMENT:</b>						
1. Ease of making appointments by phone	5	4	3	2	1	N/A
2. Appointment available within a reasonable amount of time	5	4	3	2	1	N/A
3. Getting care for illness/injury as soon as you wanted it	5	4	3	2	1	N/A
4. Getting after-hours care when you needed it	5	4	3	2	1	N/A
5. The efficiency of the check-in process	5	4	3	2	1	N/A
6. Waiting time in the reception area	5	4	3	2	1	N/A
7. Waiting time in the exam room	5	4	3	2	1	N/A
8. Keeping you informed if your appointment time was delayed	5	4	3	2	1	N/A
9. Ease of getting a referral when you needed one	5	4	3	2	1	N/A
<b>B. OUR STAFF:</b>						
1. The courtesy of the person who took your call	5	4	3	2	1	N/A
2. The friendliness and courtesy of the receptionist	5	4	3	2	1	N/A
3. The caring concern of our nurses/medical assistants	5	4	3	2	1	N/A
4. The helpfulness of the people who assisted you with billing or insurance	5	4	3	2	1	N/A
5. The professionalism of our lab or x-ray staff	5	4	3	2	1	N/A
<b>C. OUR COMMUNICATION WITH YOU:</b>						
1. Your phone calls answered promptly	5	4	3	2	1	N/A
2. Getting advice or help when needed during office hours	5	4	3	2	1	N/A
3. Explanation of your procedure (if applicable)	5	4	3	2	1	N/A
4. Your test results reported in a reasonable amount of time	5	4	3	2	1	N/A
5. Effectiveness of our health information materials	5	4	3	2	1	N/A
6. Our ability to return your calls in a timely manner	5	4	3	2	1	N/A
7. Your ability to contact us after hours	5	4	3	2	1	N/A
8. Your ability to obtain prescription refills by phone	5	4	3	2	1	N/A

Client: 1234A    Provider: BQ    Site: AL    Specialty: S04

**PLEASE COMPLETE THE OTHER SIDE**

	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
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**D. YOUR VISIT WITH THE PROVIDER:  
(Doctor, Physician Assistant, Nurse Practitioner)**

1. Willingness to listen carefully to you	5	4	3	2	1	N/A
2. Taking time to answer your questions	5	4	3	2	1	N/A
3. Amount of time spent with you	5	4	3	2	1	N/A
4. Explaining things in a way you could understand	5	4	3	2	1	N/A
5. Instructions regarding medication/follow-up care	5	4	3	2	1	N/A
6. The thoroughness of the examination	5	4	3	2	1	N/A
7. Advice given to you on ways to stay healthy	5	4	3	2	1	N/A

**E. OUR FACILITY:**

1. Hours of operation convenient for you	5	4	3	2	1	N/A
2. Overall comfort	5	4	3	2	1	N/A
3. Adequate parking	5	4	3	2	1	N/A
4. Signage and directions easy to follow	5	4	3	2	1	N/A

**F. YOUR OVERALL SATISFACTION WITH:**

1. Our practice	5	4	3	2	1	N/A
2. The quality of your medical care	5	4	3	2	1	N/A
3. Overall rating of care from your provider or nurse	5	4	3	2	1	N/A

**WOULD YOU RECOMMEND THE PROVIDER TO OTHERS?**      Yes      1      No      2

**IF NO, PLEASE TELL US WHY:** \_\_\_\_\_

**IF THERE IS ANY WAY WE CAN IMPROVE OUR SERVICES TO YOU, PLEASE TELL US ABOUT IT:**

**SOME INFORMATION ABOUT YOU:**

**GENDER**

Male      1  
Female      2

**YOUR AGE**

Under 18      1  
18-30      2  
31-40      3  
41-50      4  
51-60      5  
Over 60      6

**ARE YOU:**

A new patient      1  
A returning patient      2

*Thanks very much for your help!*