Patient Satisfaction Comment Card

Today's Date: _____

Please rate the Overall Quality of the care and services that you received during this visit.

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

Were you treated with courtesy and respect?

☐ Yes ☐ No

Were all questions regarding your procedure or discharge instructions answered?

☐ Yes ☐ No

Would you recommend our facility to a friend or loved one?

☐ Yes ☐ No

Name: _____
(optional)

What did you like about the care you received?

_____
_____
_____
_____
_____
_____
_____

What improvements do you suggest?

_____
_____
_____
_____
_____
_____
_____

Other comments?

_____
_____
_____
_____
_____
_____
_____

Please feel free to let us know at any time what we can do to make your experience better. We thank you for granting us the opportunity to serve you.

While the questions on this brochure are focused on the patient, suggestions from friends and family are always welcome.

May we call you if we have additional questions?

☐ Yes ☐ No

Patient Name

_____

Address

_____

_____

Telephone

Day (____)_____Night (____)_____

Cell (____) _____

If you are not the patient...

Your name _____

Relationship _____

Telephone

Day (____)_____Night (____)_____

Cell (____) _____