



Dear Patient:

Please rate our performance by checking the response that best describes your evaluation. Feel free to add comments. Upon completion, please return to us. Thank you for your input and feedback.

ADMITTING/REGISTRATION

Excellent Good Poor Very Poor

- | | | | | |
|--|-------|-------|-------|-------|
| 1. Professional and courteous service of office staff | _____ | _____ | _____ | _____ |
| 2. Speed and efficiency of registration | _____ | _____ | _____ | _____ |
| 3. Satisfactory answers to financial and insurance questions | _____ | _____ | _____ | _____ |

NURSING

- | | | | | |
|---|-------|-------|-------|-------|
| 4. Professional and courteous service of nurses | _____ | _____ | _____ | _____ |
| 5. Nurses introducing themselves and keeping you informed | _____ | _____ | _____ | _____ |
| 6. Nurses explaining procedures | _____ | _____ | _____ | _____ |
| 7. Satisfactory answers to questions | _____ | _____ | _____ | _____ |
| 8. Written instructions for your home care | _____ | _____ | _____ | _____ |

OVERALL

- | | | | | |
|--|-------|-------|-------|-------|
| 9. Staff giving you the privacy you needed | _____ | _____ | _____ | _____ |
| 10. Cleanliness and comfort of the surgery center | _____ | _____ | _____ | _____ |
| 11. Likelihood that you would return or recommend the Surgery Center to others | _____ | _____ | _____ | _____ |
| 12. OVERALL , rating of your experience at the Surgery Center | _____ | _____ | _____ | _____ |

Additional Comments: _____

Optional Information:

Name: _____

Address: _____