# MOUNTAIN HOME SURGERY CENTER
# PATIENT SATISFACTION SURVEY

Your assistance in completing this survey will further our Center's efforts to provide the highest level of efficient, personalized care. We would sincerely appreciate your taking a few moments to express your opinions of the care you received. Please complete and return the survey. We thank you for helping us make our Center the success it is.

Please circle the appropriate response:

1. Was the receptionist prompt and courteous during your check in? Yes No NA
   Comments_____
   _____
2. Were you seen at your scheduled appointment time? Yes No NA
   If not, how long did you wait?_____
   Comments_____
   _____
3. Was your physician understanding, patient, and caring? Yes No NA
   Comments_____
   _____
4. Was your condition and/or surgery adequately explained to you? Yes No NA
   Comments_____
   _____
5. Were the nurses understanding, patient, and caring? Yes No NA
   Comments_____
   _____
6. Were the business transactions conducted in a satisfactory manner? Yes No NA
   Comments_____
   _____
7. Were the following areas clean and comfortable?
   -reception area Yes No NA
   -recovery room Yes No NA
   -restrooms Yes No NA
   Comments_____
   _____
8. Were the instructions you received for your care at home satisfactory? Yes No NA
   Comments_____
   _____
9. Were you called by a nurse or your physician within 24 hours of your surgery? Yes No NA
   Comments_____
   _____
10. Would you recommend our services without hesitation? Yes No NA
    Comments_____
    _____
11. May we have permission to use your initials and comments on our website? Yes No

General comments_____
_____
_____
_____

_____ _____
Date Patient Name