

**CHARLOTTE ORTHOPAEDIC CLINIC, P.A.**  
**PATIENT SATISFACTION SURVEY**

**Name of Provider this survey is about:**

**To Our Patients:**

*We are interested in receiving your feedback about the care provided at our office. Please take a few minutes to complete this survey and return it to us. Your responses are important to us.*

**Please Circle your responses**

	EXTREMELY DISSATISFIED	VERY DISSATISFIED	SATISFIED	VERY SATISFIED	EXTREMELY SATISFIED
<b>How satisfied are you with the following?</b>					
1. Courtesy and friendliness of our staff on the telephone	1	2	3	4	5
2. Timeliness in scheduling an appointment	1	2	3	4	5
3. Knowledge of staff	1	2	3	4	5
4. Billing process	1	2	3	4	5
5. Answers to your questions by staff	1	2	3	4	5
6. Physician's willingness to listen and answer questions	1	2	3	4	5
7. Our Office's convenience (location, parking, office and layout)	1	2	3	4	5
8. Convenience of office hours	1	2	3	4	5
9. Ease of obtaining follow-up information as care (test results, medicines care instructions)	1	2	3	4	5
10. Wait time in office	1	2	3	4	5
11. Initial visit experience	1	2	3	4	5
12. Quality of Patient Care	1	2	3	4	5
13. Overall quality of our service	1	2	3	4	5
14. Overall consultation performed by your physician	1	2	3	4	5
	DEFINITELY WOULD NOT	PROBABLY WOULD NOT	NOT SURE	PROBABLY WOULD	DEFINITELY WOULD
15. Would you recommend your provider to your family and friends?	1	2	3	4	5

**COMMENTS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**How did you hear about us? Were you referred, if so by whom?**

\_\_\_\_\_

**Please tell us:**

**Name (optional):** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Thank you for comments and completion of this survey.**