McFarland Clinic

MEDICAL PRACTICE SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

Please rate your service with Precode 3

BACKGROUND QUESTIONS

1. If someone other than the patient is completing this survey, please check here: ..... ○
2. Was this your first visit here? ..... ○ Yes ○ No
3. How many **minutes** did you wait after your scheduled appointment time before you were called to an exam room? ☐☐☐ minutes
4. How many **minutes** did you wait in the exam room before you were seen by a doctor, physician assistant (PA), nurse practitioner (NP), or midwife? ..... ☐☐☐ minutes

INSTRUCTIONS: Please rate the services you received from our practice. <u>Select the response</u> that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely.
Example: ●

ACCESS

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Ease of getting through to the clinic on the phone	○	○	○	○	○
2. Convenience of our office hours	○	○	○	○	○
3. Ease of scheduling your appointment	○	○	○	○	○
4. Courtesy of staff in the registration area	○	○	○	○	○
5. If you use MyChart, how satisfied are you with your overall experience?	○	○	○	○	○

Comments (describe good or bad experience):_____

MOVING THROUGH YOUR VISIT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Degree to which you were informed about any delays	○	○	○	○	○
2. Wait time at clinic (from arriving to leaving)	○	○	○	○	○

Comments (describe good or bad experience):_____

NURSE/ASSISTANT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Friendliness/courtesy of the nurse/assistant	○	○	○	○	○
2. Concern the nurse/assistant showed for your problem	○	○	○	○	○

Comments (describe good or bad experience):_____

continued...

CARE PROVIDER

	very poor 1	poor 2	fair 3	good 4	very good 5

DURING YOUR VISIT, YOUR CARE WAS PROVIDED PRIMARILY BY A DOCTOR, PHYSICIAN ASSISTANT (PA), NURSE PRACTITIONER (NP), OR MIDWIFE. PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THAT HEALTH CARE PROVIDER IN MIND.

1.	Friendliness/courtesy of the care provider	○	○	○	○	○
2.	Explanations the care provider gave you about your problem or condition	○	○	○	○	○
3.	Concern the care provider showed for your questions or worries	○	○	○	○	○
4.	Care provider's efforts to include you in decisions about your treatment	○	○	○	○	○
5.	Information the care provider gave you about medications (if any)	○	○	○	○	○
6.	Instructions the care provider gave you about follow-up care (if any)	○	○	○	○	○
7.	Degree to which care provider talked with you using words you could understand	○	○	○	○	○
8.	Amount of time the care provider spent with you	○	○	○	○	○
9.	Your confidence in this care provider	○	○	○	○	○
10.	Likelihood of your recommending this care provider to others	○	○	○	○	○

Comments (describe good or bad experience):_____

_____

_____

PERSONAL ISSUES

	very poor 1	poor 2	fair 3	good 4	very good 5

1.	How well staff protected your safety (by washing hands, wearing gloves, etc.)	○	○	○	○	○
2.	Our sensitivity to your needs	○	○	○	○	○
3.	Our concern for your privacy	○	○	○	○	○
4.	Cleanliness of our practice	○	○	○	○	○

Comments (describe good or bad experience):_____

_____

_____

OVERALL ASSESSMENT

	very poor 1	poor 2	fair 3	good 4	very good 5

1.	How well the staff worked together to care for you	○	○	○	○	○
2.	Likelihood of your recommending our practice to others	○	○	○	○	○

Comments (describe good or bad experience):_____

_____

_____

If you have any questions or concerns and wish to be contacted by our Patient Relations team, please write your name and phone number below.

Patient's Name: (optional)_____

Telephone Number: (optional)_____