PATIENT SURVEY

Dear Patient,

In order to stand behind our Quality Care Assurance Program, we ask each patient to fill out this survey. Some insurance companies also require that we maintain patient surveys in our files. Each survey is reviewed and your answers are kept confidential to office management. Thank you for taking the time to fill out this survey. We hope that we have met and exceeded your expectations.

What type of device did you receive? (If not sure, please ask.)
a. Orthotic(s) b. Prosthetic(s) c. Pedorthic(s)

Was your appointment scheduled in a timely manner? YES NO

Was our staff friendly and professional? YES NO

Were our office and your room clean and comfortable? YES NO

Did our staff inform you of any expense that you may be liable for, should your insurance company deny payment? YES NO

Was your practitioner knowledgeable and attentive? YES NO

Were you given sufficient information on how to use, clean and care for your prosthetic/orthotic device(s)? YES NO

Were your items delivered in a timely manner? YES NO

Do you know how to put on and remove your device(s)? YES NO

Did your practitioner tell you to contact the office immediately if there are problems with fit/function, skin irritations or other problems? YES NO

Were you completely satisfied with your overall experience with our Practitioners and our office staff? YES NO

Additional comments/suggestions. We are always looking for ways to improve your experience here.

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May we have your email address to contact you on occasion about news or other upcoming events? ____

Patient Name ____________________________ Date ________________