Best Kids Care

Please tell us your opinion about the service you received from the provider above. Your responses will be kept strictly confidential. Thanks for your help.

PLEASE RATE THE FOLLOWING:

	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
A. YOUR APPOINTMENT:						
1. Ease of making appointments by phone	5	4	3	2	1	N/A
2. Appointment available within a reasonable amount of time	5	4	3	2	1	N/A
3. Getting care for illness/injury as soon as you wanted it	5	4	3	2	1	N/A
4. Getting after-hours care when you needed it	5	4	3	2	1	N/A
5. The efficiency of the check-in process	5	4	3	2	1	N/A
6. Waiting time in the reception area	5	4	3	2	1	N/A
7. Waiting time in the exam room	5	4	3	2	1	N/A
8. Reminding of appointment well in advance	5	4	3	2	1	N/A
9. Ease of getting a referral when you needed one	5	4	3	2	1	N/A
B. OUR STAFF:						
1. The courtesy of the person who took your call	5	4	3	2	1	N/A
2. The friendliness and courtesy of the receptionist	5	4	3	2	1	N/A
3. The skill and care of the medical assistants is adequate	5	4	3	2	1	N/A
4. The helpfulness of the people who assisted you with billing or insurance	5	4	3	2	1	N/A
5. The skill and care of the doctor/nurse practitioner is adequate	5	4	3	2	1	N/A
C. OUR COMMUNICATION WITH YOU:						
1. Your phone calls answered promptly	5	4	3	2	1	N/A
2. Getting advice or help when needed during office hours	5	4	3	2	1	N/A
3. Your test results reported in a reasonable amount of time	5	4	3	2	1	N/A
4. Our ability to return your calls in a timely manner	5	4	3	2	1	N/A
5. Your ability to contact us after hours	5	4	3	2	1	N/A
6. Your ability to obtain prescription refills	5	4	3	2	1	N/A

PLEASE COMPLETE THE OTHER SIDE

	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
D. YOUR VISIT WITH THE PROVIDER: (Doctor, Nurse Practitioner)						
1. Willingness to listen carefully to you	5	4	3	2	1	N/A
2. Taking time to answer your questions	5	4	3	2	1	N/A
3. Amount of time spent with you	5	4	3	2	1	N/A
4. Explaining things in a way you could understand	5	4	3	2	1	N/A
5. Instructions regarding medication/follow-up care	5	4	3	2	1	N/A
7. Advice given to you on ways to stay healthy	5	4	3	2	1	N/A
F. YOUR OVERALL SATISFACTION WITH:						
1. Hours of operation convenient for you	5	4	3	2	1	N/A
2. Our practice	5	4	3	2	1	N/A
3. The quality of your medical care	5	4	3	2	1	N/A
4. Overall rating of care from your provider or nurse	5	4	3	2	1	N/A

WOULD YOU RECOMMEND THE PROVIDER TO OTHERS? Yes ___ No ___

IF NO, PLEASE TELL US WHY____

____

IF THERE IS ANY WAY WE CAN IMPROVE OUR SERVICES TO YOU, PLEASE TELL US ABOUT IT:

____

____

SOME INFORMATION ABOUT YOU:

GENDER	YOUR AGE	ARE YOU:
Male	Under 18	A new patient
Female	18-30	A returning patient
	31-40	
	41-50	
	51-60	
	Over 60	

Thanks very much for your help!