Dear Patient:

Please rate our performance by checking the response that best describes your evaluation. Feel free to add comments. Upon completion, please return to us. Thank you for your input and feedback.

ADMITTING/REGISTRATION	Excellent	Good	Poor	Very Poor
1. Professional and courteous service of office staff	____	____	____	____
2. Speed and efficiency of registration	____	____	____	____
3. Satisfactory answers to financial and insurance questions	____	____	____	____
NURSING				
4. Professional and courteous service of nurses	____	____	____	____
5. Nurses introducing themselves and keeping you informed	____	____	____	____
6. Nurses explaining procedures	____	____	____	____
7. Satisfactory answers to questions	____	____	____	____
8. Written instructions for your home care	____	____	____	____
OVERALL				
9. Staff giving you the privacy you needed	____	____	____	____
10. Cleanliness and comfort of the surgery center	____	____	____	____
11. Likelihood that you would return or recommend the Surgery Center to others	____	____	____	____
12. **OVERALL**, rating of your experience at the Surgery Center	____	____	____	____

Additional Comments: _____

_____

_____

Optional Information:

Name:_____

Address:_____