# Northern Pines Health Center

Dear Patient: Our goal is to provide comfort, convenience, and satisfaction, as well as the very best medical care to all our patients. We'd like to know how you feel about our medical services, our patient-service systems, our physicians and staff members. Your comments will help us evaluate our operations to ensure that we are truly responsive to your needs. Thank you for this evaluation.

**PLEASE RATE THE FOLLOWING:**

| | Excellent | Very Good | Good | Fair | Poor | Does Not Apply |
|---|---|---|---|---|---|---|
| **A. SCHEDULING YOUR APPOINTMENT:** | | | | | | |
| 1. Ease of making appointments by phone | 5 | 4 | 3 | 2 | 1 | N/A |
| 2. Scheduling an acute care appointment (i.e. recent viral sickness, infection etc.) | 5 | 4 | 3 | 2 | 1 | N/A |
| 3. Scheduling a yearly physical, check-up, or other routine appointment. | 5 | 4 | 3 | 2 | 1 | N/A |
| 4. Ease of contacting your doctor when our office is closed? | 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 for medical staff | 5 | 4 | 3 | 2 | 1 | N/A |
| 8. Keeping you informed if your appointment time was delayed | 5 | 4 | 3 | 2 | 1 | N/A |
| **B. OUR STAFF:** | | | | | | |
| 1. The courtesy of the person taking your call and/or scheduling your appointment | 5 | 4 | 3 | 2 | 1 | N/A |
| 2. The friendliness and courtesy of our front office staff | 5 | 4 | 3 | 2 | 1 | N/A |
| 3. The caring concern of our nurses/medical assistants | 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 professionalism of the Munson lab staff | 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. Explanation of your procedure (if applicable) | 5 | 4 | 3 | 2 | 1 | N/A |
| 4. Your test results reported, and in a reasonable amount of time | 5 | 4 | 3 | 2 | 1 | N/A |
| 5. Effectiveness of our health education materials | 5 | 4 | 3 | 2 | 1 | N/A |
| 6. Our ability to return your calls in a timely manner | 5 | 4 | 3 | 2 | 1 | N/A |
| 7. Your ability to contact us after hours | 5 | 4 | 3 | 2 | 1 | N/A |
| 8. Your ability to obtain prescription refills by phone | 5 | 4 | 3 | 2 | 1 | N/A |

Please Turn Page Over and Complete Back Side

| | Excellent | Very Good | Good | Fair | Poor | Does Not Apply |
|---|---|---|---|---|---|---|
| **D. YOUR VISIT WITH THE PROVIDER: _____** **Please specify type above (Doctor, Physician Assistant, Nurse Practitioner etc.)** | | | | | | |
| 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 |
| 6. The thoroughness of the examination | 5 | 4 | 3 | 2 | 1 | N/A |
| 7. Advice given to you on ways to stay healthy | 5 | 4 | 3 | 2 | 1 | N/A |
| **E. OUR FACILITY:** | | | | | | |
| 1. Hours of operation convenient for you | 5 | 4 | 3 | 2 | 1 | N/A |
| 2. Overall comfort accessibility of office space, restroom etc. | 5 | 4 | 3 | 2 | 1 | N/A |
| 3. Signage and directions easy to follow | 5 | 4 | 3 | 2 | 1 | N/A |
| **F. YOUR OVERALL SATISFACTION WITH:** | | | | | | |
| 1. Our practice | 5 | 4 | 3 | 2 | 1 | N/A |
| 2. The quality of your medical care | 5 | 4 | 3 | 2 | 1 | N/A |
| 3. Overall rating of care from your provider | 5 | 4 | 3 | 2 | 1 | N/A |

| | Definitely Yes | Probably Yes | Don't Know | Probably Not | Definitely Not |
|---|---|---|---|---|---|
| 4. Would you recommend this provider to others? | 5 | 4 | 3 | 2 | 1 |

**IF NO, PLEASE TELL US WHY:** _____

_____

**IF WE CAN IMPROVE OUR SERVICES TO YOU IN ANY WAY, PLEASE EXPLAIN IN THE SPACE BELOW:**

_____

_____

_____

**SOME INFORMATION ABOUT YOU:**

**GENDER**

| | |
|---|---|
| Male | 1 |
| Female | 2 |

**YOUR AGE**

| | |
|---|---|
| Less than 18 yrs. | 1 |
| 18-30 yrs. | 2 |
| 31-40 yrs. | 3 |
| 41-50 yrs. | 4 |
| 51-64 yrs. | 5 |
| 65+ yrs. | 6 |

**ARE YOU:**

| | |
|---|---|
| A new patient | 1 |
| A returning patient | 2 |

***Thank you for your feedback!***