

# How Are We Doing? (PLEASE CIRCLE WHICH OFFICE )

**OAKLAND**

**LAFAYETTE**

Please take a few minutes to fill out this survey on the timeliness and quality of the service you received in our office. We welcome your feedback and your answers will be kept confidential. Thank you for your participation.

## General Patient Information

**In general, what is the quality of your health?**

- Outstanding     Good     Some chronic issues     Poor

**How would you rate our concern for your privacy?**

- Outstanding     Good     Adequate     Needs improvement     Poor     N/A

**How often have you visited [Healthcare Facility Name] within the past year?**

- First Visit     2-5 Visits     More than 6

## Scheduling Your Appointment

**Did you schedule an appointment by phone or did you drop in?**

- Scheduled by phone     Dropped in

**If you scheduled an appointment, did you have to wait longer than expected to get scheduled?**

- Yes     No

**How easy was it to make an appointment by telephone?**

- Very easy                         Very difficult

**How long did you wait to speak to a scheduling staff member?**

- 0 to 2 minutes     3 to 5 minutes     5 to 7 minutes     Longer



**Did the MA respond to your requests within a reasonable period?**

- Yes       No

**The Provider: (circle) Sommer MD, Sommer NP, Littlejohn MD, Van Leuven NP**

**Were you able to see the doctor of your choice?**

- Yes       No       N/A

**Did you feel that your doctor spent an adequate amount of time with you?**

- Yes       No       N/A

**Mark the boxes that characterize the demeanor of your doctor:**

- Attentive       Concerned       Friendly       Distracted       Rushed       Inconsiderate

**How would you rate the competence of your doctor?**

- Outstanding       Good       Adequate       Needs improvement       Poor       N/A

**Did you feel that your doctor's examination was thorough?**

- Yes       No       N/A

**Please rate the clarity of the doctor's explanation of your condition and treatment options:**

- Outstanding       Good       Adequate       Needs improvement       Poor       N/A

**How well did your doctor include you in healthcare decisions?**

- Outstanding       Good       Adequate       Needs improvement       Poor       N/A

**Were your questions answered to your satisfaction?**

- Yes       No       N/A

**Would you recommend this facility and its staff to your family and friends?**

- Yes      No      N/A

### Additional Feedback

**Please list any areas in which our service could be improved.**

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**Please share any additional comments.**

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### Personal Information

**Providing ANY of the following information is helpful but OPTIONAL.**

**Date of visit:** \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

**Would you like someone to contact you regarding your responses on this survey?**

- Yes      No

Thank you for taking the time to fill out our survey. We rely on your feedback to help us improve our services. Your input is greatly appreciated.

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