THE LASER AND SURGERY CENTER PATIENT SATISFACTION QUESTIONNAIRE

DATE YOU HAD SURGERY____________

In an effort to improve the quality of patient care in our facility, please complete this questionnaire and return to us. Please check the appropriate grade box giving explanations in the comment section as you feel necessary. Your opinion is very important in our ongoing effort to improve service to our patients..........Thank you

	A	B	C	D	F	N/A
1. The doctor and staff listened to your concerns and explained things to you in a way that you could understand.						
2. You and your family received courteous treatment by your doctor and staff.						
3. Arrangements were made to meet your special needs.						
4. Your confidentiality and privacy were maintained.						
5. How would you rate your confidence in your doctor and staff abilities.						
6. You received sufficient information to prepare you for your surgical visit.						
7. Your expected length of stay was acceptable.						
8. The environment was clean and comfortable.						
9. You or your caregiver were given adequate instructions for follow-up care at home.						
10. You received sufficient information regarding the type of anesthesia you received and were satisfied with their care.						

Would you recommend our facility to your family and friends? YES or NO

Comments:____

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