PREMIER PAIN CENTER
PATIENT SATISFACTION SURVEY

(Please check in space provided)	***Excellent***	***Good***	***Average***	***Needs to Improve***
1. In general, how do you rate our facility?	_____	_____	_____	_____
2. Our personnel: *Were they courteous, knowledgeable and quick to respond to your needs?*	_____	_____	_____	_____
Business office:	_____	_____	_____	_____
Front Office:	_____	_____	_____	_____
Nursing Personnel:	_____	_____	_____	_____
Physician:	_____	_____	_____	_____
3. Were things clean, comfortable and in working order?	_____	_____	_____	_____
4. Were your fmancial arrangements satisfactory?	_____	_____	_____	_____
5. How do you rate the waiting time?`	_____	_____	_____	_____

Would you recommend us to a friend, family member, or use us again? _____ Yes _____ No

Name of Physician: _____

General Comments and Suggestions: _____

_____

_____

_____

_____

Thank you for your assistance. You may turn in this questionnaire at discharge or mail it.

(optional) Name: _____

Daytime Phone#:_____ _____ _____ Best Time To Call:_____ am/pm

_____ Please check here if you wish to speak to someone regarding your care or concerns and a Patient Care Representative will contact you.