ORTHOPEDIC & WELLNESS

PATIENT FEEDBACK FORM

Name_____

Provider _____

Email _____

Date _____

We need your feedback in order to improve the service we provide. We want to make sure we are not only meeting your needs, but exceeding your expectations. Please take a few moments to complete this form by filling out the appropriate info and/or provide any comments, and returning it to the front desk. **Thank you for helping us better serve our patients!**

PERFORMANCE RATINGS

The following guidelines are to be used in selecting the appropriate ratings. Please select a performance rating for each of the following statements:

1 NEEDS IMPROVEMENT **2** AVERAGE **3** GOOD **4** VERY GOOD **5** EXCELLENT

BOOKING YOUR APPOINTMENT

How did you hear about Orthopedic & Wellness, LLC?

☐ AD ☐ FLYER ☐ DIRECT MAIL ☐ WEB ☐ FRIEND ☐ FAMILY ☐ OTHER

If you were referred by your physician, who is your referring physician?

_____

Were you put in contact with a new patient coordinator? Y N

If "Yes", rate your experience with the new patient coordinator. 1 2 3 4 5

Was the employee who booked your appointment helpful and friendly? Y N

Did you gain all the information you needed about your appointment? Y N

Rate your experience while booking your appointment 1 2 3 4 5

Comments:

_____

_____

THE APPOINTMENT

Upon entering OW, were you properly greeted by our staff? Y N

Was the front desk staff helpful, polite, and pleasant? Y N

Rate the front desk/administrative staff. 1 2 3 4 5

Did your appointment begin on time? Y N

If "No", how long did you have to wait? ○ 1-15 ○ 16-30 ○ Over 30 Min

Did the physician/provider explain your treatment, answer your questions, and listen to your concerns? Y N

Did you feel you had enough time with OW provider? Y N

Was the clinical staff (medical assistants, nurses, etc.) friendly, supportive and confident? Y N

Rate the clinical staff. 1 2 3 4 5

Comments:

_____

_____

Was the check out coordinator helpful and friendly? Y N

Rate your checkout experience. 1 2 3 4 5

INFORMATION

Did you gain all the information you needed about your treatment? Y N

The level of care I received was:

☐ Needs Improvement ☐ Average ☐ Good ☐ Very Good ☐ Excellent

Comments:

_____

_____

Overall, how happy were you with your experience with OW today? 1 2 3 4 5

Would you refer OW and our services to your friends, family, coworkers? Y N

Comments:

_____

_____

Further comments:

_____

_____

_____

_____

Would you like to provide feedback that will be included in our Patient Feedback & Testimonials section of our website? Y N

THANK YOU FOR COMPLETING OUR SURVEY!

Please return your completed survey to one of our front office staff before you leave. If you wish to personally speak with someone about the services we provide, or share your testimonial on our website:

Contact us at info@orthopedicwellness.com
240.629.3939

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t **240.629.3944** f **240.629.3945**

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