

# Charlottesville Wellness Center Family Practice

Dear Patient: Please tell us your opinion about the service(s) you received. Your responses will be kept strictly confidential. Thanks for your help.

## PLEASE RATE THE FOLLOWING:

5 Excellent    4 Very Good    3 Good    2 Fair    1 Poor    N/A Does Not Apply

### A. YOUR APPOINTMENT:

|  |   |   |   |   |   |     |
|--|---|---|---|---|---|-----|
| 1. Ease of making appointments by phone                      | 5 | 4 | 3 | 2 | 1 | N/A |
| 2. Appointment available within a reasonable amount of time  | 5 | 4 | 3 | 2 | 1 | N/A |
| 3. Getting care for illness/injury as soon as you wanted it  | 5 | 4 | 3 | 2 | 1 | N/A |
| 4. Getting after-hours care when you needed it               | 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                             | 5 | 4 | 3 | 2 | 1 | N/A |
| 8. Keeping you informed if your appointment time was delayed | 5 | 4 | 3 | 2 | 1 | N/A |
| 9. Ease of getting a referral when you needed one            | 5 | 4 | 3 | 2 | 1 | N/A |

### B. OUR STAFF:

|   |   |   |   |   |   |     |
|---|---|---|---|---|---|-----|
| 1. The courtesy of the person who took your call                            | 5 | 4 | 3 | 2 | 1 | N/A |
| 2. The friendliness and courtesy of the receptionist                        | 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 our 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 in a reasonable amount of time | 5 | 4 | 3 | 2 | 1 | N/A |
| 5. Effectiveness of our health information 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 COMPLETE THE OTHER SIDE**

5 Excellent    4 Very Good    3 Good    2 Fair    1 Poor    N/A Does Not Apply

**D. YOUR VISIT WITH THE PROVIDER: WHO DID YOU SEE? \_\_\_\_\_**  
(Doctor, Nurse Practitioner)

- |   |   |   |   |   |   |     |
|---|---|---|---|---|---|-----|
| 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                       | 5 | 4 | 3 | 2 | 1 | N/A |
| 3. Adequate parking                      | 5 | 4 | 3 | 2 | 1 | N/A |
| 4. 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 or nurse | 5 | 4 | 3 | 2 | 1 | N/A |

**WOULD YOU RECOMMEND THE PROVIDER TO OTHERS?**    Yes \_\_\_    No \_\_\_  
**IF NO, PLEASE TELL US WHY:**

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**IF THERE IS ANY WAY WE CAN IMPROVE OUR SERVICES TO YOU, PLEASE TELL US ABOUT IT:**

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**HAVE YOU VISITED OUR WEB SITE (CWC.FP.COM)?**    YES \_\_\_    NO \_\_\_

**HAVE YOU USED OUR PATIENT PORTAL?**    YES \_\_\_    NO \_\_\_

**SOME INFORMATION ABOUT YOU:**

Male \_\_\_ Female \_\_\_                  New patient \_\_\_                  Returning patient \_\_\_

Under 18 \_\_\_                  18 - 30 \_\_\_  
31 - 40 \_\_\_                  41 - 50 \_\_\_  
51 - 60 \_\_\_                  Over 60 \_\_\_

**Thanks very much for your help! Return this survey to the nurse or receptionist, or mail it to Office Manager, 901 Preston Ave, Ste 300, Charlottesville, VA 22903.**

6/2011