SURGICENTER PATIENT SATISFACTION SURVEY

We are interested in your opinions regarding your surgical care. Please complete the following questionnaire. Your name is OPTIONAL.

Thank you in advance for your time.

Date: _____________________________

Name (Optional): _______________________________________________

1. I was referred to Dr. Bouzaglou by: (please circle)
   a.) A Physician _____________________________________________
   b.) Health Insurance Provider ________________________________
   c.) Friend/Family (name optional) _______________________________
   d.) Other Source: ____________________________________________

2. I was able to schedule a non-emergency appointment with ease
   Yes  No

3. My time spent “holding” on the telephone was acceptable
   Yes  No

4. Is the voicemail system helpful?
   Yes  No
   Comments ______________________________________________________

5. The office staff was courteous and responsive
   Yes  No
   ______________________________________________________________
   ______________________________________________________________

6. Was the website helpful?
   Yes  No  N/A

7. How often do you use the internet?
   Frequently  Seldom  N/A

8. Have you seen our Facebook page?
   Yes  No  N/A

Pre-Operative
1. The office staff provided helpful information about billing and insurance
   Yes  No  N/A
   A) Do you have any billing questions currently? ____________________________

2. I was able to schedule my surgery with ease
   Yes  No
Comments _____________________________________________________________
_____________________________________________________________________

Surgery Experience
1. The surgical team was responsive and professional
   Yes  No

2. Was there anyone in particular that you had a positive or negative experience with?
   ______________________________________________________________
   ______________________________________________________________

Intra-Operative
1. What did you think of the Anesthesiologist? Was he/she helpful? _____________
   ______________________________________________________________
   ______________________________________________________________

   A) Were your questions answered?
      Yes  No

Post-Operative
1. Pain scale 1 to 10? _____

2. Did you experience any nausea or vomiting?
   Yes  No

Recovery
1. Was your nurse helpful?
   Yes  No
   Comments _________________________________________________________
   ________________________________________________________________

2. Did you feel your needs were met?
   Yes  No

3. Do you feel you had enough time in recovery?
   Yes  No

4. Do you remember being in the recovery room?
   Yes  No

5. What is the first thing you remember when you awoke? _____________________________
   _______________________________________________________________
   ________________________________________________________________

In Closing……..
Is there anything you would like to see changed in the SurgiCenter? _________________________
   _______________________________________________________________