

WELL CARE COMMUNITY HEALTH

PATIENT SATISFACTION SURVEY

Well Care Community Health Patient Satisfaction Survey We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous. Thank you for your time.

Please select your age group:

Under 18	<input type="checkbox"/>	55 to 64	<input type="checkbox"/>
18 to 24	<input type="checkbox"/>	65 to 74	<input type="checkbox"/>
25 to 34	<input type="checkbox"/>	75 or older	<input type="checkbox"/>
35 to 54	<input type="checkbox"/>		

Are you male or female?

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>

What do you consider to be your primary racial group?

White	<input type="checkbox"/>	Asian	<input type="checkbox"/>
Hispanic or Latino	<input type="checkbox"/>	Native Hawaiian or Other Pacific Islander	<input type="checkbox"/>
Black or African American	<input type="checkbox"/>	Two or more races	<input type="checkbox"/>
American Indian or Alaska Native	<input type="checkbox"/>	Some Other Race	<input type="checkbox"/>

Please circle how well you think we are doing in the following areas:

GREAT (5), GOOD (4), OK (3), FAIR (2), POOR (1)

Ease of getting care:

	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
Ability to get in to be seen:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hours Center is open:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convenience of Center's location:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prompt return on calls:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Waiting:

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	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
Time in waiting room:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time in exam room:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiting for tests to be performed:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiting for test results:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Provider (Physician, Dentist, Physician Assistant, Nurse Practitioner) Staff:

	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
Provider listens to you:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provider takes enough time with you:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provider explains what you want to know:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provider gives you good advice and treatment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Nurses and Medical Assistants:

	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
Friendly and helpful to you:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Answers your questions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Staff:

	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
Friendly and helpful to you:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Answers your questions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Payment:

	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
What you pay:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation of charges:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collection of payment/money:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Facility:

	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
Neat and clean building:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ease of finding where to go:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comfort and safety while waiting:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Privacy:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Confidentiality:

	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
Keeping my personal information private:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The likelihood of referring your friends and relatives to us:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you consider this clinic your main source of care?

Yes

☐

No

☐

What do you like best about our Center? What do you like least about our Center? Suggestions for improvement?

Thank you for completing our Survey!