NORTH COUNTRY HealthCare

MEDICAL PRACTICE SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

BACKGROUND QUESTIONS

1. Was this your first visit here? ○ Yes ○ No

2. How many **minutes** did you wait after your scheduled appointment time before you were called to an exam room? [| |] minutes

3. How many **minutes** did you wait in the exam room before you were seen by a doctor, physician assistant (PA), nurse practitioner (NP), or midwife? [| |] minutes

INSTRUCTIONS: Please rate the services you received from our practice. Select the response that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely. Example: ●

ACCESS

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Ease of scheduling your appointment	○	○	○	○	○
2. Ease of contacting (e.g., email, phone, web portal) the clinic	○	○	○	○	○

Comments (describe good or bad experience):

MOVING THROUGH YOUR VISIT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Degree to which you were informed about any delays	○	○	○	○	○
2. Wait time at clinic (from arriving to leaving)	○	○	○	○	○

Comments (describe good or bad experience):

NURSE/ASSISTANT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. How well the nurse/assistant listened to you	○	○	○	○	○
2. Concern the nurse/assistant showed for your problem	○	○	○	○	○

Comments (describe good or bad experience):

PREVIEW

continued...

CARE PROVIDER

	very poor 1	poor 2	fair 3	good 4	very good 5

DURING YOUR VISIT, YOUR CARE WAS PROVIDED PRIMARILY BY A DOCTOR, PHYSICIAN ASSISTANT (PA), NURSE PRACTITIONER (NP), OR MIDWIFE. PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THAT HEALTH CARE PROVIDER IN MIND.

	1	2	3	4	5
1. Concern the care provider showed for your questions or worries	○	○	○	○	○
2. Explanations the care provider gave you about your problem or condition	○	○	○	○	○
3. Care provider's efforts to include you in decisions about your care	○	○	○	○	○
4. Care provider's discussion of any proposed treatment (options, risks, benefits, etc.)	○	○	○	○	○
5. Likelihood of your recommending this care provider to others	○	○	○	○	○

Comments (describe good or bad experience):______________________

PERSONAL ISSUES

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Our concern for your privacy	○	○	○	○	○
2. How well the staff protected your safety (by washing hands, wearing ID, etc.)	○	○	○	○	○

Comments (describe good or bad experience):______________________

OVERALL ASSESSMENT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. How well the staff worked together to care for you	○	○	○	○	○
2. Likelihood of your recommending our practice to others	○	○	○	○	○

Comments (describe good or bad experience):______________________

Patient's Name: (optional)______________________

Telephone Number: (optional)______________________

PREVIEW

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