BROWARD HEALTH
Community Health Services

Customer 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.

	GREAT 5	VERY GOOD 4	GOOD 3	FAIR 2	POOR 1
Ease of getting care:					
It was easy to get in and be seen	5	4	3	2	1
Hours center is open are convenient	5	4	3	2	1
Responses to my telephone calls are prompt and courteous	5	4	3	2	1
It was easy to get an appointment for Certification	5	4	3	2	1
Health Center Appearance and Privacy:					
The building was neat and clean	5	4	3	2	1
It was easy finding where I needed to go	5	4	3	2	1
I felt comfortable and safe while waiting	5	4	3	2	1
I felt that my privacy was respected during my visit	5	4	3	2	1
My personal information was treated confidentially	5	4	3	2	1
Waiting Time:					
Time in waiting room was what I expected	5	4	3	2	1
Time in exam room was what I expected	5	4	3	2	1
Time for visit to be completed was what I expected	5	4	3	2	1
Staff and Medical Provider:					
Listened to my concerns and answered all my questions	5	4	3	2	1
The Staff spent enough time with me	5	4	3	2	1
Explained what I wanted and needed to know	5	4	3	2	1
Friendly and respectful towards me	5	4	3	2	1
Verified my name and date of birth prior to performing care	5	4	3	2	1
Overall, the services I received today were:	5	4	3	2	1

Would you feel comfortable referring your friends or relatives to us? Yes_____ No_____

Scheduled Appointment ☐ Walk In ☐

Who did you see today?

☐ Physician/Nurse Practitioner ☐ Nurse/Medical Assistant

☐ Case Manager/Social Worker ☐ Dietitian ☐ Lab

☐ Pharmacy ☐ Certification ☐ Research ☐ Other_____

Please list any positive comments and/or concerns regarding the safety of the health care services that you received. (i.e. did Staff verify your identity prior to dispensing medication or performing lab work?)_____

_____

Did we make you aware of services available to provide assistance with communication or interpretation? Yes_____ No_____

If requested, were services provided for you? Yes_____ No_____

If this was your first visit, did we provide you with information about your rights as a patient and how to express concerns you have regarding the services provided? Yes_____ No_____

What did you like best about your visit?_____

_____

_____

What did you like least about your visit?_____

_____

_____

How would you improve our services?_____

_____

Would you like us to call you about your comments: Yes_____ No_____

OPTIONAL INFORMATION:

Name:_____ **Phone:**_____

Thank you for completing our survey!

P-10211 - 113703 - (R) 5/08