

ARIZONA MEDICAL CENTER

Manjunath Nathan, M.D.

Dear Patient: To better service you please completed the below questionnaire, about the services you received during your visit with the provider. Your responses will be kept strictly confidential. Thank-you for taking the time to help us service you better.

PLEASE RATE THE FOLLOWING:	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
A. YOUR APPOINTMENT:						
1. Ease of making appointment 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 needed 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 is 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 or x-ray 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 tests 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
D. YOUR VISIT WITH THE PROVIDER: (Doctor, Physician Assistant, 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: _____

If you have any suggestions on how we can improve our services to you, please tell us your feedback:

Information about you: Please circle your response below:

Gender: Male Female

You're Age: under 16 18-30 31-40 41-50 51-60 over-60

Are you : New Patient Returning Patient