



## Patient Satisfaction Survey:

We would love to know how you feel about the services we provide so we can make sure we are meeting your needs. Your response will help us improve our services. All responses will be kept confidential and anonymous. Thank you for your time.

Age: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

New Patient \_\_\_\_\_ Returning Patient \_\_\_\_\_

Please circle how well you think we are doing in the following areas:	Excellent 5	Good 4	OK 3	Fair 2	Poor 1
<b>Your Appointment:</b>					
Ease of making appointment by phone	5	4	3	2	1
Appointment available within reasonable amount of time	5	4	3	2	1
Getting after hours care when you needed it	5	4	3	2	1
The efficiency of the check-in process	5	4	3	2	1
Waiting time in reception area	5	4	3	2	1
Waiting time in exam room	5	4	3	2	1
<b>Our Staff:</b>					
The courtesy of the person who took your call	5	4	3	2	1
The friendliness and courtesy of the receptionist	5	4	3	2	1
The caring concern of our nurses/medical assistants	5	4	3	2	1
The helpfulness of the person who assisted you with billing or insurance	5	4	3	2	1
<b>Our Communication with you:</b>					
Your phone calls answered promptly	5	4	3	2	1
Getting advise or help when needed during office hours	5	4	3	2	1
Your test results reported in a reasonable amount of time	5	4	3	2	1
Our ability to return your calls in a timely manner	5	4	3	2	1
Your ability to contact us after hours	5	4	3	2	1
Your ability to obtain prescription refills by phone	5	4	3	2	1
<b>Your visit with the provider:</b>					
Willingness to listen carefully to you	5	4	3	2	1
Taking time to answer your questions	5	4	3	2	1
Explaining things in a way you could understand	5	4	3	2	1
Instructions regarding medication/follow-up care	5	4	3	2	1
Advice given to you on ways to stay healthy	5	4	3	2	1

	Excellent 5	Good 4	OK 3	Fair 2	Poor 1
<b>Our Facility:</b>					
Hours of operation	5	4	3	2	1
Overall comfort	5	4	3	2	1
Adequate parking	5	4	3	2	1
<b>Referrals:</b>					
Ease if getting referral when you need one	5	4	3	2	1
Have you seen a specialist in the last 6 months?		Yes		No	
If Yes, What specialist did you see?					
Were you satisfied with the specialist?		Yes		No	
Were you able to get an appointment in a timely manner?		Yes		No	
<b>Your Overall satisfaction with:</b>					
Our Practice	5	4	3	2	1
The quality of your medical care	5	4	3	2	1
Our staff	5	4	3	2	1
Would you recommend the provider to others?		Yes		No	
If no please tell us why:					
If there is any other way we can improve our services to you, please tell us about it:					
Is there a staff member that you felt went above and beyond that you would like to recognize?					
Was there a specific staff member that did not meet your standards?					

## South Lyon Family Docs

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