LIBERTY MEDICAL SPECIALTIES

Patient Satisfaction Survey

Set-Up Date: _____ **Survey Date**: _____ **Type of Therapy**: _____

Below is a short survey. Receiving your comments and ratings is important to us. From this information, we can learn and adapt our services to better serve future patients. We would appreciate any comments you would like to make.

Please rate from 1 to 10 (with 10 being the highest/best rating)

STAFF

Knowledge and Professional Manner	1	2	3	4	5	6	7	8	9	10
Concern for Patient and Helpfulness	1	2	3	4	5	6	7	8	9	10
Availability for Consultation	1	2	3	4	5	6	7	8	9	10

Comments:

DELIVERY OF DRUGS/SUPPLIES/EQUIPMENT

Equipment/Drugs/Supplies were delivered when they were scheduled	1	2	3	4	5	6	7	8	9	10
Politeness and Appearance of Delivery Person	1	2	3	4	5	6	7	8	9	10
Ordering of Additional Supplies was convenient	1	2	3	4	5	6	7	8	9	10

Comments:

WAS EQUIPMENT INVOLVED IN THERAPY? ☐ Yes ☐ No

Equipment was clean and in good working condition when installed	1	2	3	4	5	6	7	8	9	10
Equipment was picked up at end of therapy	1	2	3	4	5	6	7	8	9	10

Comments:

BUSINESS OFFICE

Knowledge of Billing and Insurance Matters	1	2	3	4	5	6	7	8	9	10
Politeness and Helpfulness	1	2	3	4	5	6	7	8	9	10

Comments:

OVERALL SERVICE 1 2 3 4 5 6 7 8 9 10

What frustrations or difficulties, no matter how small, did you experience?

What comments can you make regarding any improvement we can make in our service?

If needed, would you use our service again? ☐ Yes ☐ No

CLINICIAN

Clinician was responsive to your concerns and needs	1	2	3	4	5	6	7	8	9	10
Clinician visits were scheduled and on time	1	2	3	4	5	6	7	8	9	10
Clinician training and support made Home Therapy Comfortable	1	2	3	4	5	6	7	8	9	10
Clinician overall rating	1	2	3	4	5	6	7	8	9	10

Comments:

Signature not necessary, but appreciated: _____