PATIENT SURVEY

Name (Optional) ____

By signing this form, you are consenting to allow **Wayne Physical Therapy & Spine Center**, to use and disclose the information in your survey and acknowledge that your survey may be exposed to the public, for example: website, etc., or to feedback your experience of your care to your physician.

_______________________________________ signature

______________ date

Physician ____

Physical Therapist ____

Condition Treated For ____

Treatment

1. Were you satisfied with the quality of care provided at Wayne Physical Therapy Center? Yes _____ No _____

   Comments: ____

2. Were you brought in for your appointment promptly? Yes _____ No _____

   Comments: ____

3. Did you receive treatment in a timely manner? Yes _____ No _____

   Comments: ____

4. Did your therapist provide you an opportunity to ask questions? Yes _____ No _____

   Comments: ____

5. Were your questions answered to your satisfaction? Yes _____ No _____

   Comments: ____

6. Were you satisfied with your therapist's level of competence? Yes _____ No _____

   Comments: ____

(CONT.)

7. Did your therapist have a good bedside manner? Yes _____ No _____

Comments: ____

8. Were you provided a home exercise program? Yes _____ No _____

Comments: ____

9. Were you satisfied with the results of your treatment? Yes _____ No _____

Comments: ____

Environment

1. Was the area you were treated in clean? Yes _____ No _____

Comments: ____

2. Was the atmosphere pleasant? Yes _____ No _____

Comments: ____

Office

1. Were our office personnel courteous and helpful? Yes _____ No _____

Comments: ____

2. Was scheduling appointments convenient? Yes _____ No _____

Comments: ____

3. Were our billing procedures explained fully prior to your first visit? Yes _____ No _____

Comments: ____

4. Were our office personnel helpful in filling out and/or explaining insurance forms?

Yes _____ No _____

Comments: ____

Do you have any additional comments or suggestions?

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