ROUNDUP MEMORIAL HEALTHCARE-CLINIC
1207 2ND St W   Roundup, MT 59072
Phone: 406-323-3337; Fax: 406-323-3002
www.rmhmt.org

Patient Satisfaction Survey

In order to further improve our service, we ask that you complete a Patient Satisfaction Survey. All responses are confidential and will be used to enhance the service you receive from Roundup Memorial Healthcare-Clinic.

Thank you for your time!

Did you have a **scheduled appointment** or **did you walk-in** (please circle one)

Name of the provider you saw:______________________________________

Please circle the appropriate response:

Check In/Follow Up Care

	Excellent	Very Good	Good	Fair	Poor	Does not apply
1. Your phone call was answered promptly	5	4	3	2	1	N/A
2. The receptionist was friendly and courteous	5	4	3	2	1	N/A
3. Availability of appointment at a convenient time	5	4	3	2	1	N/A
4. The efficiency of the check-in process	5	4	3	2	1	N/A
5. Waiting time in the reception area	5	4	3	2	1	N/A
6. The waiting room was clean and comfortable	5	4	3	2	1	N/A
7. You were able to schedule a convenient follow up appointment	5	4	3	2	1	N/A

Your Appointment

1. The nurse was friendly and courteous	5	4	3	2	1	N/A
2. Waiting time in the exam room	5	4	3	2	1	N/A
3. We kept you informed if there was a delay in your appointment	5	4	3	2	1	N/A
4. Exam room was clean and comfortable	5	4	3	2	1	N/A

Your Provider Visit (Doctor, Physician Assistant, Nurse Practitioner)

1. Your health care provider was friendly and courteous	5	4	3	2	1	N/A
2. Explanation of tests or procedures	5	4	3	2	1	N/A
3. Your provider listened to you	5	4	3	2	1	N/A
4. Your provider took time to answer your questions	5	4	3	2	1	N/A
5. You received a thorough exam for what you were being seen for	5	4	3	2	1	N/A
6. You understood instructions for medications, home care, follow up	5	4	3	2	1	N/A
7. You receive your test results in a timely manner	5	4	3	2	1	N/A

Our Facility

1. Our hours of operation are convenient for you	5	4	3	2	1	N/A
2. Is there adequate parking	5	4	3	2	1	N/A
3. Signage and directions are easy to follow	5	4	3	2	1	N/A

PLEASE COMPLETE THE OTHER SIDE

Your Overall Satisfaction With:

	Excellent	Very Good	Good	Fair	Poor	Does not apply
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	5	4	3	2	1	N/A

WOULD YOU RECOMMEND OUR CLINIC TO OTHERS? Yes No

IF NO, PLEASE TELL US WHY:____

____

IS THERE ANY WAY WE CAN IMPROVE OUR SERVICES TO YOU?______________________

____

Some information about you, please circle

Your age: under 18
18-30
31-40
41-50
51-60
Over 60

Are you: A new patient
A returning patient

If you would like to be contacted regarding this survey or on any aspect of your clinic visit, please provide your first name and phone number :____

THANK YOU VERY MUCH FOR YOUR HELP!