PATIENT SATISFACTION SURVEY

To help us in our commitment to quality assurance, please complete the following survey and return in the self addressed stamped envelope.

PATIENT NAME: _____

DATE OF DELIVERY: _____

ITEMS DELIVERED: _____

DELIVERY TECHNICIAN: _____

Were you properly instructed on the use of the supplies/equipment? ____Yes ____No

Was your delivery technician friendly? ____Yes ____No

Were all of your questions answered? ____Yes ____No

Did the delivery technician go over all of your paperwork? ____Yes ____No

Were you given warranty/repair information? ____Yes ____No

Was our return policy explained to you? ____Yes ____No

Were you told how to voice a complaint to us? ____Yes ____No

Was financial responsibility discussed with you? ____Yes ____No

Did the delivery technician go over home safety of the equipment? ____Yes ____No

How would you rate Medicare's rules regarding home medical equipment and the impact these rules have on your access to the products and services you believe you require?
____Excellent ____Good ____Fair ____Poor

How would you rate your overall satisfaction with the delivery experience on a scale of 1-10? (10 being exceptional and 1 being poor)
1 2 3 4 5 6 7 8 9 10

Notes/Comments: _____

_____

_____

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Signature: _____ Date: _____