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FamilyCare HEALTH CENTERS

Site: _____

Date of Visit: _____

Spring 2018 Patient Experience Survey

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. We will use your responses to improve our services. All responses will be kept confidential and anonymous. Please answer all questions on both pages. Thank you for your time.

Please indicate the type of service provided during today's visit: Primary Care ☐ Behavioral Health ☐ Dental ☐ OB/GYN ☐

Name of the provider you saw during your visit: _____

Please mark the appropriate box to tell us how you think we are doing in the following areas:	Excellent	Good	Fair	Poor	(N/A)
1. Convenience of health center hours?					
2. How easy was it to schedule a visit with this health center?					
3. Length of time you had to wait before seeing the provider?					
4. Confidentiality of personal information:					
5. How would you rate the courtesy of our staff?					
6. If you phone the office after regular hours, is the reply prompt enough to suit your needs?					

	Yes, definitely	Yes, somewhat	No	N/A
7. Did your provider listen to you carefully?				
8. Did your provider have a good understanding of your health history?				
9. Did the provider talk with you about *your* specific goals for your health?				
10. Did the provider explain what to do if your condition gets worse?				
11. In the last 12 months, have you received any reminders from this office about test results and/or medication changes?				

12. On a scale of 0-10, how likely are you to recommend this health center to others?
(Circle One) - Not At All Likely 0 1 2 3 4 5 6 7 8 9 10 Extremely Likely -

13. Please indicate the following for the person seen by the provider today: (Circle age of appropriate gender)

Male	Under 18	18 - 24	25 - 34	35 - 44	45 - 64	65 +
Female	Under 18	18 - 24	25 - 34	35 - 44	45 - 64	65 +
Other	Under 18	18 - 24	25 - 34	35 - 44	45 - 64	65 +

14. How was your visit paid for? (circle one)

Medicare	Medicaid	Insurance	Self-Pay	Worker's Comp	Medicaid/CHIP	Sliding Fee

15. If you have additional comments or suggestions for improvement, please enter them below (you may also use the back of this sheet if needed):

_____

_____

_____

_____

_____

WV Primary Care Association

Thank you for your participation. The information obtained via this survey is confidential. Survey results are compiled by the WVPCA as a member benefit for Health Centers.

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How would you rate the way your financial arrangements were handled?					
(Circle One)	Excellent	Good	Fair	Poor	N/A

If you have been approved for sliding fee, (check appropriate box)	**Yes**	**No**
Did you find the amount you owe to be fair?		
Did you have difficulty paying the amount owed?		
Does your sliding fee amount ever stop you from seeking care?		

Additional Comments: