

MEREDYTH EYE SURGERY CENTER

2709 Meredyth Dr., Suite 210
Albany, GA. 31707

Patient Satisfaction Survey

It is our desire to provide our patients with the best quality of care available. Please help us by completing the following form and returning it back on your next visit.

	Excellent (5)	Good (4)	Average (3)	Poor (2)	Needs Improvement (1)
1. Was our check-in service prompt and courteous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Were the waiting rooms clean and comfortable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Please rate the comfort in the pre and post-operative areas.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. <u>Our staff and physicians:</u> Were they courteous, knowledgeable, and responsive to your needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Did the overall time in the surgery center meet your expectations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How likely would you be to recommend our staff/physicians/facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please make any comments you feel would help us improve in any way.

If you have a complaint regarding your care, please contact:

Tina Harrison, RN, Nurse Manager
2709 Meredyth Dr., Suite 210
Albany, GA 31707
Phone/Fax: 229-878-0974
Email: tharrison@bergeye.com

Name (optional): _____ Date of Surgery: _____