



associates in
women's health care
a division of genesis ob/gyn, p.c.

How Are We Doing?

At **Associates in Women's Health Care** it is our intention to provide exceptional medical care to all of our patients, and create an environment in which you feel welcomed, cared about and catered to!

In order to better serve you, we would appreciate you taking the time to complete the following survey. If you would like your answers to remain confidential, please do not place your name at the bottom of this survey.

Please indicate your experience with Associates in Women's Health Care by using the following scale:

- 5 – exceeds expectations
- 4 – mostly exceeds expectations
- 3 – meets expectations
- 2 – mostly meets expectations
- 1 – below expectations

1. When you called to schedule your appointment:

- | | | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. | Was your call answered in a reasonable amount of time | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | If you left a message, did you receive a return call within an acceptable period of time | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | Was your appointment scheduled on a convenient day and time | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. | Was our scheduling representative professional, courteous and friendly | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. | Was your appointment scheduled with your provider of choice | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

2. When you arrived for your appointment:

- | | | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. | Was our front office staff professional, courteous and friendly | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | Were you escorted to an exam room within a reasonable amount of time after your scheduled appointment time | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | Was our lobby comfortable | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

3. When you entered your exam room:

- | | | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. | Was your exam room clean and neat | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | Was the clinical staff professional, courteous, and friendly | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | Did you feel you had enough time with your provider | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. | Did your provider answer all your questions | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. | Do you feel your provider cared about your needs | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

4. When checking out:

- | | | | | | | |
|----|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. | Was the staff professional, courteous and friendly | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | Did the staff answer your questions in a professional and knowledgeable manner | 1 | 2 | 3 | 4 | 5 |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | If you made a payment during your visit, were you supplied with a detailed receipt? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | |
| d. | If a follow-up appointment or test was scheduled, were you provided with an appointment card? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | |

Comments: _____

5. Overall, how would you rate our performance as a medical group committed to the health and well being of women

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1 | 2 | 3 | 4 | 5 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: _____

6. Is there anyone in our practice that you would like to give a special word of thanks?

Comments: _____

7. If you had the choice, which hospital would you prefer?

- | | | |
|--------------------------|--------------------------|--------------------------|
| TMC | St. Joseph's | UMC |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Northwest | St. Mary's | |
| <input type="checkbox"/> | <input type="checkbox"/> | |

Comments: _____

Thank you for taking the time to complete this questionnaire. We appreciate your input and are looking forward to improving our relationship with our patients.

If you would like to speak to someone regarding your experience with Associates in Women's Health Care, please provide your name, telephone number and the best time to reach you below.

Name (print) Telephone number Best time to call _____am/pm

Please check one of the following: OB Patient GYN Patient