PATIENT SATISFACTION SURVEY

We are pleased that you and your doctor chose Minimally Invasive Spine Center. Our goal is to provide high quality care for you and your family. Your evaluation will be thoroughly reviewed and kept confidential. Please return this form within 7 days of your procedure. We're available at 303-539-2533 betwen 8:00 AM and 5:00 PM to answer any questions you may have. Please indicate below your overall impression of our center based upon the services you received during your outpatient visit. If your overall impression was not excellent, what would it take to make it excellent?

Please indicate your choice by filling in the squares for each question. Choose only one square for each item.

How many days were there between the day your appointment was made and the day of your procedure?

☐ Same day ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15 days or greater

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	N/A
This wait time was acceptable	☐	☐	☐	☐	☐	☐
Pre-Surgery instructions, delivered to me by phone call or at my facility visit, were clear and courteous	☐	☐	☐	☐	☐	☐
The registration process was prompt and efficient	☐	☐	☐	☐	☐	☐
The registration staff was courteous	☐	☐	☐	☐	☐	☐
Billing and insurance information were clearly explained to me upon registration	☐	☐	☐	☐	☐	☐

How many minutes did you wait in the waiting room before your procedure?

☐ 0-5 minutes ☐ 6-10 minutes ☐ 11-20 minutes ☐ 21-30 minutes ☐ Over 30 minutes

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	N/A
This wait time was acceptable	☐	☐	☐	☐	☐	☐
A clear explanation was provided regarding any delay to the start of my procedure	☐	☐	☐	☐	☐	☐
The physician and the staff provided a clear and complete explanation regarding the plan for sedation prior to the procedure	☐	☐	☐	☐	☐	☐
The Facility Staff: Responded efficiently to my questions, needs and concerns	☐	☐	☐	☐	☐	☐
Showed concern for my comfort	☐	☐	☐	☐	☐	☐
Showed concern for my privacy	☐	☐	☐	☐	☐	☐
Maintained appropriate confidentiality during my stay	☐	☐	☐	☐	☐	☐
Provided a clear explanation of the discharge instructions	☐	☐	☐	☐	☐	☐
The quality of nursing care I received was good	☐	☐	☐	☐	☐	☐
The facility was clean	☐	☐	☐	☐	☐	☐

	Yes	No
Would you recommend the Minimally Invasive Spine Center to a good friend who lives in the area, has a medical problem similar to yours, and needs outpatient surgery?	☐	☐

Patient name _____

Your physician's name _____ Date of procedure _____

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We welcome all comments, positive and negative. If you gave us a low rating or encountered difficulties with a staff member, we want to know what we can do to improve our services to you and others. Please write your comments in the box below.

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