Form Approved
OMB Form No. 0917-0036
Expiration Date:

PATIENT SATISFACTION SURVEY

Please complete this survey AFTER you are finished with your visit a our employees.

Instructions: **Please circle your answers below.**

Team Receiving Care from: Green Blue Red Zia Santa Ana Optometry Other:________

Age Range: 1-15 16-30 31-45 46-60 61-75 75>

Gender: Male Female

Indicate your answer to corresponding questions by placing an "X" in the table below.

Scheduling & Registration…	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Don't Know**
I am satisfied with the ability to schedule my visit on a convenient date and time					
I am satisfied with the registration process					
My Health Views…					
I am sure I can manage and control most of my health problems.					
My Medical Provider….					
I know who my medical provider is					
They explain information in a way that is easy to understand					
They talk to me about my health problems and concerns					
They give me easy-to-understand instructions about taking care of my health					
My provider spends enough time with me					
My provider is thorough enough with my needs and concerns					
My provider talks with me about making changes in my life to prevent illness					
My provider asks me about my concerns or worries					
My provider asks me about how I'm feeling; my mental health – if I'm sad, empty, or feeling down					
My Care Team …					
I know my team members (RN's, Clerks, Pharmacist, etc.)					
My care team lets me know when my appointment is delayed					
I know my care is provided by a team that works with me, this includes seeing other professionals (dietician, pharmacy, etc.)					
My family is included when needed in patient care decision, treatment, and education.					
The care team treats me with respect to my cultural beliefs					
I feel I can reach and talk with my care team when I need to					
I would recommend this clinic to my friends and family					

I receive exactly the care I want and need exactly when and how I want it.					
Wait Time…					
I am satisfied with the total amount of time spent waiting.					

COMMENTS – Improvements? Recognition? Suggestions? :

***After your visit* please submit by:**

-Leaving in the Room

OR

-Submitting to any Care Team Member

OR

-Turning them into the Collection Bins located in the Waiting Room

OR

-Mail back to:

Patient Satisfaction Coordinator
Lola Atkins, CNE
801 Vassar Dr.
Albuquerque, NM 87106

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0917-0036-36. The time required to complete this information collection is estimated to average 2 minute per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336E, Washington D.C. 20201. Attention: PRA Reports Clearance Officer.

Patient Satisfaction Survey

Keep through your *whole* clinic visit to provide us with your important feedback regarding

your experiences in each section.

We Care About Your Opinion.

Thank you!