

## Patient Satisfaction Quality Assurance

**Date:** \_\_\_\_\_

**We want to know what you thought about today's telehealth session. Your honest answers will help us improve the system. Please circle the number that is closest to your own opinion for each of the following statements.**

	STRONGLY DISAGREE	DO NOT AGREE	DO NOT AGREE	DO NOT AGREE	STRONGLY AGREE
<b>Example:</b> <i>I felt well when I woke up this morning.</i>	1	2	3	4	5
<i>I felt comfortable with the equipment used.</i>	1	2	3	4	5
<i>I was able to see the clinician clearly.</i>	1	2	3	4	5
<i>I was able to hear the clinician clearly.</i>	1	2	3	4	5
<i>There was enough technical assistance for my meeting with the clinician.</i>	1	2	3	4	5
<i>My relationship with the clinician was the same during this session as it is in person.</i>	1	2	3	4	5
<i>The location of the telehealth clinic is convenient for me.</i>	1	2	3	4	5
<i>My needs were met during the session.</i>	1	2	3	4	5
<i>I received good care during the session.</i>	1	2	3	4	5
<i>Overall, I am satisfied with this telehealth session.</i>	1	2	3	4	5
<i>I would recommend this type of session to others.</i>	1	2	3	4	5
<i>I would rather use telehealth to receive this service than travel to see my provider.</i>	1	2	3	4	5

If you would like to be contacted, please provide you name and phone number.

**Name:** \_\_\_\_\_