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

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Patient Satisfaction Survey

We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving our services. Your responses will be kept in confidence and only reviewed by our administrative staff. Thank you for your time.

Your Age:

How far did you travel to get here today?

(Pleas	How do you rate? se circle the appropriate number)	Excellent	Very Good	Fair	Poor	Very Poor
1.	The time it took us to answer your call or schedule your appointment	5	4	3	2	1
2.	The manner of the person who scheduled your appointment	5	4	3	2	1
3.	Your wait time to be screened after you checked in	5	4	3	2	1
4.	Your screeners retrieval of vital signs	5	4	3	2	1
5.	Your nurse's review of medications and Assessment	5	4	3	2	1
6.	Your wait time in the room before the provider arrived	5	4	3	2	1
7.	The amount of time spent with your provider.	5	4	3	2	1
8.	The provider listening to you.	5	4	3	2	1
9.	The provider's explanation of procedure, diagnosis, or treatment?	5	4	3	2	1
10	. Overall quality of care and service provided by IHS.	5	4	3	2	1
11	I have a person who I think of as my personal doctor or nurse.	Strongly Agree⁵	Agree⁴	Neutral ³	Disagree ²	Strongly Disagree
12	. I am able to get the care I need and want - when I need and want it at the clinic.	Strongly Agree⁵	Agree⁴	Neutral ³	Disagree ²	Strongly Disagree
13	. I am sure that I can manage and control most of my health problems.	Very sure or No health problems ⁵	Somewha t sure⁴	Neutral ³	Not very sure ²	Not at all
	you have any suggestions or covices?	omments as t	o how we n	nay bettei	r improve o	ur

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. The time required to complete this information collection is estimated to average five minutes 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

Thank you for taking the time to complete this survey. Your opinion means a lot to

accuracy of the time estimate(s) or suggestions Suite 336E, Washington D.C. 20201, Attention: F	for improving this form, please write t PRA Reports Clearance Officer.	o: U.S. Department of Health & Huma	nn Services, OS/OCIO/PRA, 200 Indep	endence Ave., S.W.,