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Procedure Patient Satisfaction Survey

Thank you for taking the time to complete this survey. Your feedback allows us to continuously improve our services. We do not plan to contact you regarding this survey, but if you wish to be contacted, please sign your name at the end of survey. Directions: Please rate the following criteria using a 1-5 scale by drawing a circle around the appropriate number.

1 is Poor, 5 is excellent, circle N/A for Non-Applicable. Thank you.

- | | | | | | | |
|--|---|-----|---|----|---|-------|
| 1. Convenience of hour of operations? | 1 | 2 | 3 | 4 | 5 | N/A |
| 2. Promptness and courteousness of the people answering telephone? | 1 | 2 | 3 | 4 | 5 | N/A |
| 3. Satisfaction with procedure start time? | 1 | 2 | 3 | 4 | 5 | N/A |
| Was it within 20 mins of your scheduled appointment? | | Yes | | NO | | |
| 4. How courteous and friendly was our staff? | 1 | 2 | 3 | 4 | 5 | N/A |
| 5. Satisfaction with the care from the Physician? | 1 | 2 | 3 | 4 | 5 | N/A |
| Satisfaction with the care from the Anesthesiologist? | 1 | 2 | 3 | 4 | 5 | N/A |
| 6. How well were you informed about your procedure before you arrived at our center? | 1 | 2 | 3 | 4 | 5 | N/A |
| 7. How would you rate your overall experience at the Center? | 1 | 2 | 3 | 4 | 5 | N/A |
| 8. Did you have any pain following the procedure? | | YES | | NO | | |
| 9. Would you like to recognize a staff member? | | | | | | _____ |
| 10. Additional comments: | | | | | | _____ |
| | | | | | | _____ |

Name _____ Date _____