## HCA CUSTOMER SURVEY

## **Directions**

- Use a number 2 pencil or Blue or Black ink pen Fill in bubble completely
  - · Correct mark:

· Incorrect marks:

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Our organization wants to provide you and your family with the highest quality care possible. To help us evaluate and improve our services, we would like your opinion about us. The information you provide is confidential. Thinking about the service you receive, please rate the following by filling in the space on each line that best represents your opinion. If you have not experienced the specific item asked about in a question, please darken the "Not Applicable" option.

	Please respond to the questions as they apply to services at:						
	I. OVERALL	Not Applicable	Poor	Fair	Good	Very Good	Excellent
١	a. Overall, how would you evaluate the quality of service you received?	0					0
•	2. INTERACTION	Not Applicable	Poor	Fair	Good	Very Good	Excellent
• [	a. Helpfulness of staff	0	0			0	
	b. Courtesy shown to you by staff						0
• [	c. Concern of staff						
• [	d. Attention to privacy						
• [	e. Degree of confidentiality			0	0	0	0
•	f. Professionalism of staff	0	0	0	0	0	0
•	3. CLINICAL PROGRAM	Not Applicable	Poor	Fair	Good	Very Good	Excellent:
	a. Opportunity to participate in decisions about your treatment		0		0	0	0
•	b. Extent to which your individual needs were addressed						
	c. Organization of weekday program schedule	0		0		0	
•	d. Organization of weekend / holiday program schedule	0	0		0	0	0
	e. Appropriate therapies & interventions offered	0	0	0	0	0	0
8	f. Ability of services to meet your needs						
•	g. Availability of staff to talk with you						0
	h. Ease of completing paperwork						
	4. ACCESS	Not Applicable	Poor	Fair	Good	Very Good	Excellent
	a. Convenience of location of facility	0		0			
	b. Signs and directions to treatment areas					0	
	c. Ability to reach desired department or person by phone			0	0		
	d. Hours appointments are available		$\bigcirc$				
100	e. Length of time between making appointment and seeing the psychiatrist						
	f. Length of time between making appointment and seeing the therapist / counselor	0	0		0		
88	g. Time spent in waiting area for your scheduled appointment	0			0		
	5. ENVIRONMENT	Not Applicable	Poor	Fair	Good	Very Good	Excellent
	a. Safety of the environment	0	0			0	0
	b. Comfortable feeling			0			0
	c. Noise level						

5. ENVIRONMENT (cont)		Not Applicable	Poor	Fair	Good	Very Good	Excellen
d. Attractiveness of the facility		0					
e. Cleanliness of the facility		0					
f. Provision of necessary convenience items		0					
g. Desirability of food		0	0	0			
h. Availability of refreshments or snacks		0		0	0		
6. FINANCE / BUSINESS OFFICE		Not Applicable	Poor	Fair	Good	Very Good	Exceller
a. Arrangements for you to pay bill without unnecessary	hardship	0					
b. Reasonableness of fees		0					
7. OUTCOME AND REPUTATION		Not Applicable	Poor	Fair	Good	Very Good	Excelle
a. Degree to which treatment helped you deal with your	problem / complaint	0	0	0	0		
b. Willingness to return for treatment		0					
c. Reputation of our organization		0		0		0	
d. Overall quality of care and services		0					
		1					
I. Would you recommend our organization to other	rs? \\ \\ 9. Enter too	lay's date:	Mon	th D	av	Year	
Would you recommend our organization to other     Yes	rs? 9. Enter too	lay's date:	Mon	000		Year	Œ
	9. Enter too	day's date:	JAN C FEB C MAR C		13) (25) (14) (26) (15) (27)	19 (1) 20 (1) (2)	(D) (D) (2)
□ Yes □ No □	9. Enter too	lay's date:	JAN C FEB C MAR C APR C MAY C		13 25 1 14 26 1 15 27 16 28 17 29	19 (1) 20 (1) (2) (3) (4)	(D) (D) (2) (3) (4)
Yes  2. Have you completed treatment?		lay's date:	JAN C FEB C MAR C APR C MAY C JUN C JUL C AUG C		130 (25) (140 (26) (150 (27) (160 (28) (17) (29) (180 (30) (19) (31) (20)	19 (D) (Z) (Z) (3) (4) (5) (5) (7)	(D) (C) (C) (C) (C) (C) (C) (C) (C) (C) (C
Yes  2. Have you completed treatment?  Yes  No  No  Yes  No  Yes  No  No  Yes		lay's date:	JAN C FEB C MAR C APR C JUN C JUN C SEP C OCT C NOV C		13 (25) (14) (26) (15) (27) (16) (29) (18) (30) (19) (31) (20) (21) (22) (23)	19 (1) 20 (1) (2) (3) (4) (5)	(I) (I) (I) (I) (I) (I) (I) (I) (I) (I)
Yes  2. Have you completed treatment?  Yes  3. You came to our program with certain problems. How are those problems now?  Worse Somewhat worse A great deal better		lay's date:	JAN C FEB C MAR C APR C JUN C JUL C AUG C SEP C OCT C NOV C DEC C	0 (1) (1) (2) (3) (4) (5) (5) (6) (7) (6) (7) (7) (7) (7) (7) (7) (7) (7) (7) (7	13 (25) (14) (26) (15) (27) (16) (29) (18) (30) (19) (31) (20) (21) (22) (23)	19 (I) 20 (I) (2) (3) (4) (5) (6) (7)	
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