

## PERCEPTION OF CARE/SATISFACTION SURVEY

You are our valued customer and your opinion is important to us. Completion of this survey will help us improve our services to you and to others who use services.

	Very Satisfied	Somewhat Satisfied	Not Satisfied	Not Applicable
1. Was the equipment/orthotic/prosthetic in good working order and with a clean and neat appearance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Did your equipment/orthotic/prosthetic arrive at the scheduled delivery time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Were customer service personnel and the Orthotic/Prosthetic Fitter or delivery personnel knowledgeable about your equipment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Were you adequately instructed in the use and care of the equipment/device to allow you to comfortably use your equipment/orthotic/prosthetic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Were our company service personnel friendly, professional and courteous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Were you informed about our 24-hour availability, our after-hours telephone and your rights and responsibilities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Were you informed about our grievance/complaint process and the 24-hour state hot line?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you been able to obtain help/services after hours by using our after-hours telephone number?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have all questions regarding payment or billing been handled to your satisfaction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has the equipment/supplies/orthotic/prosthetic performed as expected?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has our customer service staff helped you in a timely, courteous fashion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Were our hours and location convenient?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: \_\_\_\_\_

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*We appreciate the time taken to complete and return this survey.*

Optional: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

If you'd like to be contacted about our services, please list your name and telephone number.