ERIE COUNTY COMMUNITY HEALTH CENTER CONSUMER SURVEY

Thank you for completing this survey.

At the end of your visit, please deposit the completed survey in the confidential survey box.

Was this your first visit to the Health Center? YES NO Date of Visit: _____ Time of Visit: _____ AM PM

PLEASE RATE THE SERVICES WE PROVIDED USING THE SCALE AS LISTED:

SCHEDULING / REGISTRATION	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Availability of desired appointment day and time					
Ability to schedule appointment with one call					
Speed of Registration Process					
Sensitivity to privacy/personal information					
Overall rating of scheduling/registration staff					
NURSES / DENTAL STAFF					
Courtesy/Professionalism of Nursing/Dental staff					
Promptness in calling you to exam room					
Staff responded to all of your questions					
Level of privacy/confidentiality provided					
Communication to you regarding any delays					
Sensitivity to beliefs and cultural needs					
Overall rating of nursing/dental staff					
PHYSICIAN / NURSE PRACTITIONER / DENTIST					
Waiting time for Physician/Nurse Practitioner/Dentist					
Responded to all of your questions/concerns					
Used language you can understand					
Provided information you need to manage your symptoms/medical or dental problem for you to make informed decisions for you plan of care					
Sensitivity to beliefs/cultural needs					
Level of privacy/confidentiality provided					
Overall rating of physician/nurse practitioner/dentist					
FACILITIES					
Cleanliness of facility					
Equipment/facility is up to date					
Overall rating of care received					
Likelihood of recommending Health Center to others					
The nominal fee (if applicable and paid by you) is a fair charge for the services received.					

Preferred Appointment Time: Morning ☐ Afternoon ☐ Evening (after hours) ☐ Urgent Care ☐ Same Day ☐

Comments: (Please share your experience and offer any suggestions for ways we can improve our services to you)

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If you desire a call from a member of our management team, please complete the following information:

Name _____ Phone Number _____

SERVICES PROVIDED: (CHECK ONE) Family Practice ☐ Pediatrics ☐ Prenatal/Gynecology ☐ Dental ☐ Immunizations ☐ Other ☐ _____

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Thank you! Please deposit the survey in the confidential survey box.