

J & K ORTHOPEDICS, INC
320 E BONITA AVENUE
POMONA, CA 91767
PHONE (909) 621-1180
FAX (909) 625-7535



J & K ORTHOPEDICS, INC
224 W COLLEGE, STE B
COVINA, CA 91723
PHONE (626) 331-8856
FAX (626) 915-3011

Patient Satisfaction Survey

Your satisfaction with our service is important to us. Please take a moment to share your perception about the care you received. This information will be used to help us to improve our care and all of your responses will be held in the strictest confidence.

Patient Name:

Practitioner:

Device:

DOS:

Referral Source:

Insurance:

Please respond to each of the following questions:

1. What is your level of satisfaction with the care you received?

extremely satisfied very satisfied satisfied somewhat satisfied not satisfied

2. The amount of time that the practitioner spent with you?

extremely satisfied very satisfied satisfied somewhat satisfied not satisfied

3. The friendliness, courtesy, and professionalism of the practitioner and staff?

extremely satisfied very satisfied satisfied somewhat satisfied not satisfied

4. The overall quality, fit, and comfort of your device?

extremely satisfied very satisfied satisfied somewhat satisfied not satisfied

5. The amount of time that it took to deliver your device?

extremely satisfied very satisfied satisfied somewhat satisfied not satisfied

6. The amount of information you received on how to use, clean and care for your device?

extremely satisfied very satisfied satisfied somewhat satisfied not satisfied

7. Which of the following best represent your understanding of your doctor's goals for you?

___ reduce pain/increase comfort

___ enhance function and independence

___ provide joint stability

___ prevent deformity

___ increase range of motion

___ address cosmetic issue and/or promote healing

8. Did you have other goals than those listed above?

___ No ___ Yes _____

9. Were the above mentioned goals realistically met?

___ No ___ Yes

10. Would you use our services again?

___ No ___ Yes

11. Which of the following did you find have a problem in scheduling your appointment?

___ Medical Group/IPA

___ Insurance Company

___ Your physician

___ J & K Orthopedics, Inc.

Why?

Any Additional Comments:

Signature: _____

Date: _____

Phone: _____

Thank You! Please return survey in envelope provided.