



Patient Satisfaction Survey

Date: _____

In an effort to improve our quality of care, please take a moment to answer all the questions below:

Please circle how well we are doing in these areas:	Never	Sometimes	Usually	Always
Access:				
It was easy to schedule an appointment	1	2	3	4
It was easy to schedule a same-day appointment	1	2	3	4
The phone calls were answered promptly/returned in a timely manner	1	2	3	4
It was a short wait time to see a provider after check-in	1	2	3	4
Communication:				
The provider explained things that were easy to understand	1	2	3	4
The provider listened carefully and showed respect to me	1	2	3	4
The provider spent enough time with me	1	2	3	4
Coordination of Care:				
Southland's staff followed up to give the results of blood tests, X-ray or other tests	1	2	3	4
Southland's staff went over my current prescriptions with me	1	2	3	4
The provider seemed informed and up-to-date about my specialty care	1	2	3	4

A. How did you hear about Southland Integrated Services?

- ☐ Family/Friends
 ☐ TV/Radio
 ☐ Events/Outreach
 ☐ Outside Providers
 ☐ Social Media
 ☐ Other _____

B. Would you recommend Southland to a family member or a friend? ☐ Yes ☐ No

C. Do you currently have insurance coverage (Medi-Cal, Medicare, or commercial insurance)?
☐ Yes ☐ No

D. Have you been informed of **Southland's Sliding Fee Discount Program** (regardless if you have insurance or other forms of health coverage)?
☐ Yes ☐ No

E. If you are not currently signed up for **Southland's Sliding Fee Discount Program**, are you interested in applying?
☐ Yes ☐ No (skip to G)

F. If you are signed up for **Southland's Sliding Fee Discount Program**, at any time in the past 12 months, has Southland's nominal fee prevented you from seeking necessary health services at Southland?
☐ Yes ☐ No

Please see back



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G. What could we have done differently to improve your experience today?

Thank you for taking your time to complete the survey. Please only include your identification information if you would like to be contacted for a follow up.

Name: _____

Phone: _____

FOR STAFF USE ONLY:

Patient's Sliding Scale:

☐ A ☐ B ☐ C ☐ D ☐ E

Insurance (based on patient's demographic):

☐ A ☐ B ☐ C ☐ D ☐ E

Service(s) this patient received today: ☐ Medical ☐ Dental ☐ BH ☐ Acu ☐ OT ☐ Other____