HARMONY HEALTHCARE
CLIENT SATISFACTION SURVEY

NAME (Optional)____________________________________ DATE_________________________________

We are interested in your overall experiences based on all visits or contacts you have had during your treatment. Using the scale below, please score each aspect of the services you have received. If you score a question with a 1 or 2, please let us know the reason that particular question received that score.

1. Please rate the timely manner in which your appointments were scheduled.  ______
   (Were you able to get in to see your provider in a timely manner)

2. Please rate your satisfaction with the customer service line.  ______
   (Was the Call Center rep courteous, knowledgeable, caring, professional)

3. How would you rate your satisfaction with the compassion shown to you at Harmony?  ______

4. Please rate your satisfaction with the frequency of visits to your prescribing practitioner.  ______

5. How would you rate the cleanliness of the waiting room?  ______

6. How would you rate the professionalism of the front office staff?  ______

7. How courteous was the front office staff?  ______

8. Ability of your counselor(s) to listen to and understand your problems.  ______

9. Professional knowledge and competence of the main counselor.  ______

10. How would you rate the quality of care received from your counselor?  ______

11. If applicable, please rate the quality of care you received from your prescriber.  ______

12. Confidentiality and respect for your rights as an individual?  ______

13. How would you rate the overall services at Harmony Healthcare?  ______

14. Degree to which the services have helped you deal more effectively with your problem.  ______

15. While at Harmony were all your concerns addressed?  ______

16. Did Harmony staff demonstrate genuine concern for you?  ______

17. Who is your counselor at which clinic  ________________

   In your own words, please explain any concerns or complaints that this survey has not addressed:
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

Would you like a response to your concerns?  Yes____ No____ Phone # ____________________________

Submitted to the Quality Department for Review: Yes____ No____ DATE____________________

Review completed on________________________________________BY_____________________

Patient informed of response to concern by mail: Yes_____ No_____ Date_____________________

Signature of Reviewer: ________________________________