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	**2**	**3**	**4**
Poor	Fair	Good	Excellent

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:_____