

Spectrum Radiology Associates, PLLC
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Patient Satisfaction Survey

Please tell us about the service you received. You may also contact us via email at contact@spectrumradiology.com. Your responses will be kept strictly confidential. Thank you.

**PLEASE RATE THE FOLLOWING ON A SCALE OF 1-5
(1-POOR, 2-FAIR, 3-GOOD, 4-VERY GOOD, 5-EXCELLENT)**

- | A. YOUR APPOINTMENT: | SCORE |
|--|--------------|
| 1. Ease of making appointment by phone | _____ |
| 2. Appointment available within a reasonable amount of time | _____ |
| 3. Efficiency of the check-in process | _____ |
| 4. Waiting time in the reception area | _____ |
| 5. Keeping you informed if your appointment time was delayed | _____ |
|
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| B. OUR STAFF: | |
| 1. The courtesy of the person who took your call | _____ |
| 2. The friendliness and courtesy of the receptionist | _____ |
| 3. The caring concern of our technologists/nurses | _____ |
| 4. The helpfulness of the people who assisted you with billing/insurance | _____ |
|
 | |
| C. OUR COMMUNICATION WITH YOU: | |
| 1. Your phone calls answered promptly | _____ |
| 2. Explanation of your procedure | _____ |
| 3. Your test results reported in a reasonable amount of time | _____ |
|
 | |
| D. OUR FACILITY: | |
| 1. Hours of operation convenient for you | _____ |
| 2. Overall comfort | _____ |

E. YOUR OVERALL SATISFACTION WITH:

SCORE

1. Our practice
2. The quality of your medical care
3. Overall rating of care from the technologist

WOULD YOU RECOMMEND SPECTRUM RADIOLOGY TO OTHERS? Y N
IF NO, PLEASE TELL US WHY:

**IF THERE IS ANY WAY WE CAN IMPROVE OUR SERVICES TO YOU, PLEASE
TELL US ABOUT IT:**

SOME INFORMATION ABOUT YOU:

GENDER:	M	F
YOUR AGE:	Under 18 18-30 31-40 41-50 51-60 Over 60	
YOUR ARE:	A new patient A returning patient	

**IF YOU WOULD LIKE TO DISCUSS CONCERNS WITH ADMINISTRATION,
PLEASE LEAVE YOUR CONTACT INFORMATION BELOW:**

Thank you very much!