etc **Physical Therapy** **Patient Discharge Survey**

As a valued patient, we appreciate you taking a few moments to fill out this survey. We believe your satisfaction is the key to our continued success and would like to know your comments.

Patient Name: _____ Date: _____

Physician: _____ Clinic: _____

Please use the following scale to rate each area.

4	=	Excellent	2	=	Average
3	=	Good	1	=	Poor

- Overall satisfaction with your experience: _____
- Appropriate treatment for your condition: _____
- Scheduling process: _____
- Billing and financial assistance: _____
- Clinic appearance: _____

For what condition were you treated for?

Which therapist(s) treated you for your condition?

Who may we thank for referring you?

Is there anything we could do to improve our service?

Would you recommend a friend or family member in the future?

If we had a location open for treatment on Saturday, would this be a benefit to you?

May we share this information with your referring physician?

General Comments: