## Philmont Guidance Center—Patient Satisfaction Survey

INSTRUCTIONS: Please answer the following questions and rate the services you received at our center. Circle the number that best describes your experience. If you did not receive a service, leave that question blank and go to the next question. Please include any additional comments you may have. After you are finished, please place the completed survey in the designated survey collection box or return it to one of our staff members.

Today's Date: _____ / _____ / _____

Please circle the site you visited: Huntington Valley Flourtown Doylestown

Is someone other than patient completing survey? yes no
If yes, what is your relationship to patient? _____

Patient's sex Male Female
Patient's age _____

| | very poor | poor | fair | good | very good |
|---|---|---|---|---|---|
| **OVERALL SATISFACTION WITH YOUR VISIT TO PGC**: | | | | | |
| **CENTER AVAILABILITY** | very poor | poor | fair | good | very good |
| 1. Ease of scheduling your appointment | 1 | 2 | 3 | 4 | 5 |
| 2. Courtesy of person who scheduled your appointment | 1 | 2 | 3 | 4 | 5 |
| 3. Helpfulness of staff on telephone | 1 | 2 | 3 | 4 | 5 |
| 4. Center's timeliness in returning your calls | 1 | 2 | 3 | 4 | 5 |

COMMENTS: _____
_____
_____

| **WHILE YOU WERE AT OUR CENTER** | very poor | poor | fair | good | very good |
|---|---|---|---|---|---|
| 1. Ease of registration process | 1 | 2 | 3 | 4 | 5 |
| 2. Courtesy/friendliness of front desk staff | 1 | 2 | 3 | 4 | 5 |
| 3. Comfort and pleasantness of waiting area | 1 | 2 | 3 | 4 | 5 |
| 4. Comfort and pleasantness of therapy rooms | 1 | 2 | 3 | 4 | 5 |
| 5. Our concern for your privacy | 1 | 2 | 3 | 4 | 5 |

**YOUR THERAPIST'S NAME:** _____

| | very poor | poor | fair | good | very good |
|---|---|---|---|---|---|
| 1. Friendliness/courtesy of your therapist | 1 | 2 | 3 | 4 | 5 |
| 2. Therapist has a good understanding of your problems | 1 | 2 | 3 | 4 | 5 |
| 3. Therapist provides you with practical help | 1 | 2 | 3 | 4 | 5 |
| 4. Therapist is available when there is an emergency | 1 | 2 | 3 | 4 | 5 |
| 5. Ease of scheduling follow up appointments | 1 | 2 | 3 | 4 | 5 |

(over)

**YOUR PSYCHIATRIST'S NAME (IF APPLICABLE): _____**
**(SKIP THIS SECTION IF YOU DO NOT SEE A PHILMONT PSYCHIATRIST)**

| | | | | | |
|---|---|---|---|---|---|
| 1. Friendliness/courtesy of your psychiatrist | 1 | 2 | 3 | 4 | 5 |
| 2. Psychiatrist has a good understanding of your problems | 1 | 2 | 3 | 4 | 5 |
| 3. Psychiatrist answers questions about medication in a clear fashion | 1 | 2 | 3 | 4 | 5 |
| 4. You feel confident about your psychiatrist's abilities | 1 | 2 | 3 | 4 | 5 |
| 5. Ease of scheduling follow up appointments | 1 | 2 | 3 | 4 | 5 |

Would you recommend Philmont Guidance Center to others? Yes No
Please explain your answer: _____
_____
_____

Are there services that we currently do not provide that would be helpful to you or your family? _____
_____
_____

Are there any difficulties you encounter when you are trying to receive care at our center? _____
_____
_____

COMMENTS: _____
_____
_____
_____

Was there any staff member that was particularly helpful? Yes No

If yes, who? _____

Your Name (Optional): _____

I would like to talk to someone further about my experiences at Philmont Guidance Center:

No
Yes please list your telephone number(s): Day: _____

Eve: _____

**We are always trying to find ways to improve our service—thank you for your help!**

**Please place this completed form in an envelope and mail to:**

**Philmont Guidance Center, PC**
**PO Box 366**
**Fort Washington, PA 19034**