2021 PHYSICIAN OFFICE SATISFACTION SURVEY

We are committed to providing the best imaging services and experience possible to your office and your patients.
The most valuable tool we have for evaluating our service is your feedback and perspective.
Thank you for taking the time to make your comments available to us, and for referring to our centers.

What is your position in the office?

MD	Chiropractor	PA/NP	RN	Office Manager	Referral Coordinator	Other

PLEASE RATE US ON THE FOLLOWING USING A SCALE OF 1-4 **TODAY'S DATE:** ___________________

OPERATIONS	Rating 1=POOR 4=EXCELLENT (indicate number or N/A)		COMMENTS (Any positive/negative feedback)
Ease of getting through by phone		Rating or N/A	
Ease of scheduling an appointment		Rating or N/A	
Friendliness of staff		Rating or N/A	
Image quality		Rating or N/A	
Report turnaround time		Rating or N/A	
Access to images/reports online if applicable (web portal)		Rating or N/A	
RADIOLOGISTS			**COMMENTS**
Accuracy / Quality of reports		Rating or N/A	
Availability for consultation		Rating or N/A	
PATIENT EXPERIENCE FEEDBACK			**COMMENTS**
Customer Service		Rating or N/A	
Cleanliness of our facility		Rating or N/A	
Location / Access to our facility		Rating or N/A	
OVERALL			**COMMENTS**
How well do we anticipate your needs		Rating or N/A	
Likelihood you will refer to our center again		Rating or N/A	
Our service favorably differentiates us from other imaging providers		Rating or N/A	

ADDITIONAL COMMENTS:	
What is most memorable about our service?	
What one thing could we do to enhance our service to your practice?	
Other comments? (use back of page if necessary)	

You may choose to remain anonymous or provide us with identification so we may follow-up on your specific needs.

Office Name: ________________________ **Evaluator's Name:** ________________________

Please Fax or Email your completed survey to:

Sales Representative Fax: ____________________ **Email:** ____________________

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