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Ophthalmology & Ophthalmic Surgery

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Patient Satisfaction Survey

The team at EyeCare Associates of Texas is continually striving to bring you the best care possible. It is our goal to have extremely satisfied patients and your input is essential to this process. We care about your viewpoint and response to the services we provide. Please take a moment to reflect on your experiences and respond to the following questions. Thank you for choosing EyeCare Associates of Texas for your eye care needs, and thank you for helping us improve our customer service.

How satisfied were you with the following services:

	Excellent	Very Good	Good	Fair	Poor	NA
1. Appointment Availability/Timeframe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Telephone Professionalism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Check In Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Wait Time to see Physician/Assistants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Work-up by Clinical Assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Exam by the Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Physician explanation of Diagnosis/Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Checkout Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Surgery Scheduling/Follow Up Appointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Optical Department/Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Contact Lens Department/Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Facility Cleanliness/Neatness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Clarity of Billing Correspondence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Considering everything, how satisfied were you with your recent experience at Eyecare Associates of Texas?

Very Satisfied Somewhat Satisfied Not Satisfied

How likely are you to refer your friends and family to EyeCare Associates of Texas?

Very Likely Somewhat Likely Not Likely

How likely are you to visit Eyecare Associates of Texas the next time you need eye care?

Very Likely Somewhat Likely Not Likely



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Are there any doctors or staff members who provided exceptional customer service during your visit with Eyecare Associates of Texas?

Comments or Suggestions:

Thank you for sharing your comments and ideas. We look forward to the opportunity to serve you and others while incorporating your suggestions.

Would you like to be contacted regarding your comments? Yes No

Optional Information:

(If you choose to answer the questions below your name will be automatically entered into the monthly drawing for a \$25 gift card to places such as **Red Lobster or Olive Garden**)

Location of your eye care visit? Duncanville Midlothian Grand Prairie

Name: _____

Date of Visit: _____

Phone Number: _____

Physician's Name: _____

(Please feel free to use the bottom of this page for additional comments)