McLaren CARO REGION

RENUE PHYSICAL THERAPY

PATIENT EXPERIENCE SURVEY

McLaren Caro Region Renue Physical Therapy

Date: _____

Patient Name: _____

Therapist Name: _____

Referring Physician: _____

Please rate your experience at our clinic based on the following factors.

1. The front desk staff was courteous, helpful and caring to me.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

2. My first appointment was scheduled in a timely manner.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

3. The physical therapist team understood my condition.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

4. The physical therapist(s) explained my condition and procedures in a way I could easily understand.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

5. The clinic was clean and equipment worked properly.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

6. The billing process was streamlined and easy to follow.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

7. I would return to and/or recommend this clinic for physical therapy care in the future.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

8. I am satisfied with the overall quality of my physical therapy care.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree

9. Please rate your total experience with the clinic:

- ☐ Excellent
- ☐ Above average
- ☐ Below average
- ☐ Poor

10. How did you hear about our clinic?

- ☐ Physician referral
- ☐ Internet
- ☐ Friend/family
- ☐ Advertising
- ☐ Return patient
- ☐ Other _____

11. May we tell your referring physician about your physical therapy experience?

☐ Yes ☐ No

12. May we use your first name when sharing a testimonial for marketing purposes?

☐ Yes ☐ No

13. Our goal is to exceed your expectations and make you a "patient for life." Please share a testimonial about your experience or suggestions for improvement below:

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