

Hawse Health Center

Patient Satisfaction Survey

REVISED 3/8/2022

For one week every six months, Hawse Health Center asks that our patients complete this survey. We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your answers are directly responsible for improving our services. All surveys will be kept confidential and anonymous. If you would like to discuss a suggestion or concern, please feel free to add your name and contact information. Thank you.

Your Age: _____ Who did you see today? _____

Town/City Where you live? _____

Are you here for Medical ____ or Dental ____ or Behavioral Health

How did you hear about our Center? _____ Family Member _____ Friend
 _____ Yellow Pages _____ Newspaper Advertisement
 _____ Other: _____

What do you like best about our Center? _____

What do you like least about our Center? _____

Suggestions for Improvement? _____

Tell us a little about your experience today:	Great 5	Good 4	OK 3	Fair 2	Poor 1
EASE OF GETTING CARE:					
* Ability to get in to be seen	5	4	3	2	1
* Hours the Center is open	5	4	3	2	1
* Convenience of Center's location	5	4	3	2	1
* Prompt return on calls	5	4	3	2	1
WAITING:					
* Time in waiting room	5	4	3	2	1
* Time in exam room	5	4	3	2	1
* Waiting for tests to be performed	5	4	3	2	1
* Waiting for test results	5	4	3	2	1
STAFF:					
Provider: (Physician, Dentist, Physician Assistant, Nurse Practitioner:					
* Listens to you	5	4	3	2	1
* Takes enough time with you	5	4	3	2	1
* Explains what you want to know	5	4	3	2	1
* Gives you good advice and treatment	5	4	3	2	1

OVER →→→→

	GREAT 5	GOOD 4	OK 3	FAIR 2	POOR 1
Tell us a little about your experience today:					
DENTAL ASSISTANTS OR MEDICAL ASSISTANTS:					
* Friendly and helpful to you	5	4	3	2	1
* Answers your questions	5	4	3	2	1
ALL OTHER STAFF:					
* Friendly and helpful to you	5	4	3	2	1
* Answers your questions	5	4	3	2	1
PAYMENT:					
* What you pay	5	4	3	2	1
* Explanation of charges	5	4	3	2	1
* Collection of payment/money	5	4	3	2	1
* If you have been approved for sliding fee, do you: (circle one)					
1. Find the amount you owe to be fair?	YES	NO			
2. Have difficulty paying the amount owed?	YES	NO			
3. Does your sliding fee amount ever stop you from seeking care?	YES	NO			
FOLLOW UP & EDUCATION:					
* Do you understand how to take care of your health problems after this visit?	5	4	3	2	1
* Do you understand who to call when you have questions?	5	4	3	2	1
* Do you understand when to come to the clinic for your next visit?	5	4	3	2	1
* Do you understand WHY you should call the clinic?	5	4	3	2	1
FACILITY:					
* Neat and clean building	5	4	3	2	1
* Ease of finding where to go	5	4	3	2	1
* Comfort and Safety while waiting	5	4	3	2	1
* Privacy	5	4	3	2	1
CONFIDENTIALITY:					
* Keeping my personal information private	5	4	3	2	1
The likelihood of referring your friends and relatives to us?	5	4	3	2	1
The likelihood of returning for care in the future?	5	4	3	2	1
Do you consider this center your regular source of care? Yes _____ No _____					

PLEASE INDICATE YOUR HOUSEHOLD INCOME LEVEL

Household Members	Less than 100% Poverty Level A	101%-150% Poverty Level B	151%-200% Poverty Level C	Over 200% Poverty Level D
1	\$13,590	\$13,591 - \$20,385	\$20,386 - \$27,180	\$27,181
2	\$18,310	\$18,311 - \$27,465	\$27,466 - \$36,620	\$36,621
3	\$23,030	\$23,031 - \$34,545	\$34,546 - \$46,060	\$46,061
4	\$27,750	\$27,751 - \$41,625	\$41,626 - \$55,500	\$55,501
5	\$32,470	\$32,471 - \$48,705	\$48,706 - \$64,940	\$64,941
6	\$37,190	\$37,191 - \$55,785	\$55,786 - \$74,380	\$74,381
7	\$41,910	\$41,911 - \$62,865	\$62,866 - \$83,820	\$83,821
8	\$46,630	\$46,631 - \$69,945	\$69,946 - \$93,260	\$93,261