Patient Satisfaction Survey
For the Practice of Kathryn M. Gardner, M.D.

We would greatly appreciate your assessment of the health care provided by our office. Please mail this questionnaire to our office at your convenience. Thanks!

1= Agree Strongly 2= Agree 3= No opinion 4=Disagree 5= Disagree Strongly
N/A= Not Applicable (circle one)

- *I was able to contact the office and schedule my appointment without undue delay or difficulty.*
  1 2 3 4 5 N/A

- *The office staff was courteous on the telephone, and provided me with the information I needed to prepare for my appointment*
  1 2 3 4 5 N/A

- *I received a confirmation call for my appointment.*
  1 2 3 4 5 N/A

- *I felt that the waiting time in the office prior to my appointment was acceptable.*
  1 2 3 4 5 N/A

- *The office was comfortable and inviting, and the equipment was clean.*
  1 2 3 4 5 N/A

- *The staff treated me with respect and protected my privacy during my visit.*
  1 2 3 4 5 N/A

- *During my visit, the doctor asked me about my current health and eye care issues.*
  1 2 3 4 5 N/A

- *I felt comfortable sharing my concerns with the doctor.*
  1 2 3 4 5 N/A

- *I felt that the doctor spent an adequate amount of time examining me.*
  1 2 3 4 5 N/A

- *The doctor explained her findings to me in a way that I could understand.*
  1 2 3 4 5 N/A

- *I felt that the doctor included me in planning my eye health management, and took note of my personal circumstances and needs.*
  1 2 3 4 5 N/A

- *I felt confident that I could reach the doctor in case of a question or an emergency.*
  1 2 3 4 5 N/A

- *I would recommend Dr. Gardner to a friend or family member.*
  1 2 3 4 5 N/A

Please add any comments about how we might improve your eye health care experience:

____

____

____

____