



Clarkston Medical Group  
Pediatrics • Internal Medicine • Urgent Care

# Satisfaction Survey

## How Are We Doing?

Date: \_\_\_\_\_

Please take a few minutes to fill out this survey on the timeliness and quality of the service you received today. Clarkston Medical Group welcomes your feedback and your answers will be kept confidential. Thank you for your participation.

### General Questions

**Are you aware of our extended patient care hours?** (Open until 8:00pm M-Th, 5:30pm Fri, 12pm Sat)

- Yes
- No

**Did you have to wait longer than expected to get a scheduled appointment?**

- Yes
- No

**How long did you wait to speak to a scheduling staff member?**

- 0 to 2 minutes
- 3 to 5 minutes
- 5 to 7 minutes
- Longer
- N/A (Scheduled in Office)

**How would you rate the courtesy of the person who scheduled your appointment?**

- Very courteous
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- 
- 
- 
- 
- Rude

**How would you rate the courtesy of the staff at the reception desk?**

- Very courteous
- 
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- 
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- Rude

**How would you rate the competence of the nurse/medical assistant who helped you?**

- Outstanding
- Good
- Adequate
- Needs improvement
- Poor
- N/A

**Did you feel that your doctor spent an adequate amount of time with you?**

- Yes
- No

**\*TURN OVER TO COMPLETE\***

**Did your doctor discuss health care goals such as; diet and exercise with you?**

- Yes       No       N/A

**Please rate the clarity of the doctor's explanation of your condition and treatment options:**

- Outstanding       Good       Adequate       Needs improvement       Poor       N/A

**Were your questions answered to your satisfaction?**

- Yes       No       N/A

**If you needed a follow up appointment, were you asked to schedule the appointment at check-out?**

- Yes       No       N/A

**Would you recommend this facility and its staff to your family and friends?**

- Yes       No       N/A

### Additional Feedback

**Please list any areas in which our service could be improved.**

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**Please share any additional comments.**

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### Personal Information

**Providing the following information is optional.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Provider Seen: \_\_\_\_\_

**Thank you for taking the time to fill out our survey. We rely on your feedback to help us improve our services. Your input is greatly appreciated.**

**Please return form to:** Clarkston Medical Group  
5701 Bow Pointe Dr. #100  
Clarkston, MI 48346  
Attn: Health Management Department