Ability Rehabilitation

Patient Name (optional): _____ Date: _____
Clinic Location: _____ Physician: _____

Thank you for volunteering to complete this survey. We appreciate and value your honest feedback. The information that you provide us will be kept confidential, and will be used to gain a better understanding of your experience in therapy. Through this process, we hope to identify our strengths and weaknesses, and make the necessary improvements to enhance the overall patient experience at Ability Rehabilitation Centers.

Please rate the criteria below, based on the following scale:	Very Poor	Poor	Average	Good	Excellent
Overall					
Overall level of satisfaction	1	2	3	4	5
I would recommend Ability Rehabilitation to a friend	1	2	3	4	5
Clinical Care					
Professionalism of your therapist(s)	1	2	3	4	5
Quality of treatment received	1	2	3	4	5
Effectiveness/results of the treatment	1	2	3	4	5
Confidence in your therapists' skills/knowledge	1	2	3	4	5
Level of one-on-one attention received	1	2	3	4	5
Appointments starting on time	1	2	3	4	5
Reception					
Professionalism of the front office personnel	1	2	3	4	5
Phone etiquette of personnel	1	2	3	4	5
Timeliness of scheduling the first appointment	1	2	3	4	5
Meet your scheduling needs with follow-up appointments	1	2	3	4	5
Explanation of insurance benefits	1	2	3	4	5
Facility					
Appearance of the facility	1	2	3	4	5
Condition of the equipment	1	2	3	4	5

Please describe the factors that had a positive impact on your experience.

_____
_____
_____

Please suggest one area of improvement that would have made a significant difference in your overall experience.

_____
_____
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Revised: 9/2014