Accucare, Inc.
PATIENT SATISFACTION SURVEY

Date:_____

Dear Patient,

It is our desire to provide you with the best quality services available. In order to help us maintain our high standards, please take a few moments to tell us how we are doing. Please complete this form and mail it back to us. Thank you.

Was your equipment (and supplies if applicable) delivered on time?	❑ YES	❑ NO
Was the equipment (and supplies if applicable) delivered / dispensed accurately?	❑ YES	❑ NO
Was the training and consultations effective in educating you or your caregiver on your equipment (and supplies if applicable)?	❑ YES	❑ NO
Was the educational materials and instructions provided adequate to educate you or your caregiver on the product(s) provided?	❑ YES	❑ NO
Was the company staff courteous and helpful?	❑ YES	❑ NO
Were your financial responsibilities explained to you?	❑ YES	❑ NO
Did you receive advice or help when requested?	❑ YES	❑ NO
Did the services provided make a positive impact on the outcome of your care?	❑ YES	❑ NO
Would you recommend our services to friends and family?	❑ YES	❑ NO
Did the services provided meet your needs and expectations?	❑ YES	❑ NO

COMMENTS (OPTIONAL)

Signature (optional)_____