PIVOTAL | MED SUPPLY

PATIENT SATISFACTION SURVEY

To help us in our commitment to quality assurance, please complete the following survey and return it in the self-addressed stamped envelope.

PATIENT NAME: _____

DATE OF DELIVERY: _____

ITEMS DELIVERED: _____

DELIVERED BY: Fedex

How would you rate your overall satisfaction with the service experience on a scale of 1-10? (10 being exceptional and 1 being poor)

1. Your equipment/service was provided in a timely manner? ☐ Y ☐ N
2. Were you properly instructed on the use of the supplies/equipment? ☐ Y ☐ N
3. Were all of your questions answered? ☐ Y ☐ N
4. Were you given warranty/repair information? ☐ Y ☐ N
5. Was our return policy explained to you? ☐ Y ☐ N
6. Were you told how to voice a complaint to us? ☐ Y ☐ N
7. Was financial responsibility discussed with you? ☐ Y ☐ N
8. Would you recommend us to friends and family? ☐ Y ☐ N

How would you rate Medicare's rules regarding home medical equipment and the impact these rules have on your access to the products and services you believe you require?
Excellent ☐ Good ☐ Fair ☐ Poor ☐

How would you rate your overall satisfaction with the delivery experience on a scale of 1-10? (10 being exceptional and 1 being poor)

Notes/Comments: _____

_____

_____ _____

Signature Date: