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CUSTOMER SATISFACTION SURVEY

Harmony Hand and Physical Therapy would like to know about your therapy experience. Your responses will be helpful in our mission to provide excellent care and customer service. After completing this short survey, please mail or place the survey into the comment box or mail back to us.

- | | Agree | Disagree | N/A |
|--|--------------------------|--------------------------|--------------------------|
| 1. I was able to schedule my first appointment within a reasonable amount of time..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. The receptionists were pleasant and helpful..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. My financial responsibilities were clearly explained to me..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. The length of waiting at the time of appointments was minimal..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. The clinic/treatment area was clean and orderly..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. My therapist was professional, thorough, and paid attention to my needs..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. I am satisfied with the therapist(s) I had my appointment with..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. The goals of the therapy program were shared with me and I had input..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. The home program or instructions were clear and easy to follow..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. I would return and/or recommend this clinic to others..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please list any positive experiences you encountered with your treatment program:

Please list any negative experiences you encountered with your treatment program:

Optional:

Name: _____ Phone Number: _____

Would you like us to contact you regarding any specific concern about your rehabilitation visit? Yes No

Thank you for taking this time to help us. If you have any questions regarding this survey, or any of our services, please call Brenda Cummings at (970) 204-4263.