

YOUR OPINION COUNTS!

We would like your help with our desire to continually improve our office. In the day-to-day hustle and bustle of providing care, we may not recognize what is really great about our clinic, or what may need some attention. Let us know what you think, and do not be shy about sharing your thoughts. For each question, circle the one answer that best describes your feelings about your care at Kennedy Vision. Thank you!

Registration: **Excellent** **Good** **Fair** **Poor**

Efficiency of patient registration: 4 3 2 1

Courtesy/friendliness of our staff: 4 3 2 1

Our Care:

Courtesy of Technicians: 4 3 2 1

Courtesy of Doctors: 4 3 2 1

Explanation of procedures performed: 4 3 2 1

Thoroughness of Exam 4 3 2 1

Concern for the patient's well being: 4 3 2 1

Contact Lenses: (if applicable):

Received lenses in a timely manner: 4 3 2 1

Received the correct lenses 4 3 2 1

Prices: 4 3 2 1

Optical (if applicable):

Selection of Frames: 4 3 2 1

Knowledge about the product: 4 3 2 1

Wait to receive glasses product: 4 3 2 1

Prices: 4 3 2 1

The Facility: **Excellent** **Good** **Fair** **Poor**

Appearance of the Clinic: 4 3 2 1

Cleanliness of Clinic: 4 3 2 1

Directions to Clinic: 4 3 2 1

Location: 4 3 2 1

Employees:

Employees you wish to comment about: _____

Overall Perception:

Would you recommend Kennedy Vision Health Center to you're Family and Friends? ___ Yes ___ NO (If No Why?)

What did you like the best? _____

Did we meet your expectations? ___ Yes ___ NO

Please feel free to make ANY comments on the other side!!!

Optional: Name: _____