Amputee Prosthetic Clinic
Toll Free: 888.FAKELEG
888fakeleg.com

PATIENT SURVEY

AMPUTEE PROSTHETIC CLINIC

Dear Patient:
In order to stand behind our Quality Assurance & Integrity Program, we are asking all patients who receive services from our practice to complete this survey. Our Quality Assurance & Integrity Team reviews and evaluates each and every survey on a daily basis so we will know whether to enhance a particular area of our practice to serve our patients better. We strive for excellence and hope you have experienced that during your office visit. Thank you for taking the time to complete this survey. When completed, simply save and email this to our office at info@apcgeorgia.com, or print and hand to our Receptionist at your next office visit. We hope that we have met or exceeded your expectations. Please call our office if we can provide additional assistance to you.

1. What type of device did you receive? (If you're not sure, please ask any of our staff for assistance.)
   ◯ Orthotic(s) ◯ Prosthetic(s) ◯ Pedorthic(s) ◯ Mastectomy ◯ Other:
2. How would you rate your appointment time & scheduling?
   ◯ Excellent ◯ Above Average ◯ Average ◯ Below Average ◯ Poor
3. How would you rate your experience with, and knowledge of, our insurance department staff?
   ◯ Excellent ◯ Above Average ◯ Average ◯ Below Average ◯ Poor
4. Did our staff inform you of any expense that you may be liable for should your insurance company deny or reduce payment for services rendered to you?
   ◯ Yes ◯ No Comments:
5. Did you agree to pay for any expenses you may incur if your insurance company denies or reduces payment of your claim?
   ◯ Yes ◯ No Comments:
6. How would you rate the knowledge, care, and attention that our Practitioner provided to you during your visit?
   ◯ Excellent ◯ Above Average ◯ Average ◯ Below Average ◯ Poor
7. Overall, how would you rate your new device and does it meet your satisfaction?
   ◯ Excellent ◯ Above Average ◯ Average ◯ Below Average ◯ Poor
8. Were you given verbal and/or written instructions on the use and care of your new device?
   ◯ Yes ◯ No Comments:
9. Were you completely satisfied with the overall experience you encountered by our Practitioners and staff during your visit?
   ◯ Yes ◯ No Comments:
10. Were you asked to call our office, or make another appointment for a follow-up if necessary?
    ◯ Yes ◯ No Comments:

Additional Comments/Suggestions:

Patient Name: Date: