Southwest Virginia Community Health Systems, Inc.
PATIENT SURVEY SITE NAME: _____

Telephone (276)496-4492/Fax (276)496-4839
www.svchs.com

WELCOME TO OUR PATIENT CENTERED MEDICAL HOME OFFICE! IN ORDER FOR US TO IMPROVE ON OUR SERVICE TO YOU, OUR PATIENT AND THE COMMUNITY, WE HAVE DEVELOPED THIS SURVEY QUESTIONNAIRE. IT WILL ENABLE US TO CONTINUE TO PROVIDE YOU AND YOUR FAMILY WITH THE APPROPRIATE CARE. YOUR HEALTH AND YOUR OPINION IS IMPORTANT TO US. IF YOU HAVE ANY PROBLEMS OR CONCERNS, YOU MAY LIST THEM IN THE "COMMENTS" SECTION OF THIS FORM. THIS INFORMATION WILL BE REVIEWED BY THE EXECUTIVE DIRECTOR, SVCHS, INC.'S BOARD OF DIRECTORS AND THE ENTIRE STAFF. YOUR INPUT WILL BE APPRECIATED.

RESPECTFULLY,

BRYAN HAYNES
EXECUTIVE DIRECTOR

1. WHEN YOU ARRIVED AT THE OFFICE, WAS THE AREA CLEAN AND THE APPEARANCE PLEASING? ☐YES ☐NO
2. Were the provider and staff friendly and courteous? ☐YES ☐NO
3. IN THE PAST 12 MONTHS, HOW MANY DAYS DID YOU HAVE TO WAIT FOR AN APPOINTMENT? ☐ 1 DAY ☐ 2 DAYS ☐ MORE THAN 2 DAYS
4. IN THE PAST 12 MONTHS, DID YOU NEED CARE OR MEDICAL ADVICE IN THE EVENINGS OR ON THE WEEKENDS? ☐YES ☐NO
5. WERE YOU ABLE TO CONTACT OUR "ON CALL" PROVIDER FOR ADVICE AFTER HOURS? ☐YES ☐NO
   IF SO, WHAT WAS THE RESPONSE TIME? ☐ 1 HOUR OR LESS ☐ 2 HOURS OR MORE
6. IN THE PAST 12 MONTHS, DID YOU CALL THE OFFICE AND GET A RETURN CALL FROM A STAFF MEMBER WITHIN THE SAME BUSINESS DAY? ☐YES ☐NO
7. DID YOU GET A CALL OR VOICEMAIL REMINDING YOU OF YOUR APPOINTMENT DATE AND TIME? ☐YES ☐NO
8. DID THE PROVIDER OR OTHER STAFF GIVE YOU EDUCATIONAL INFORMATION THAT WAS EASY TO UNDERSTAND? ☐YES ☐NO
9. DID THE STAFF GIVE YOU A SUMMARY OF YOUR VISIT ON LEAVING THE OFFICE? ☐YES ☐NO
10. DURING YOUR VISIT, DID THE STAFF DISCUSS THE SVCHS, INC. PATIENT PORTAL WITH YOU? ☐YES ☐NO
11. HAVE YOU VISITED OUR WEBSITE? ☐YES ☐NO
    IF NOT, WHY? ☐ NO COMPUTER/INTERNET ACCESS ☐ DID NOT KNOW ABOUT IT ☐ NOT INTERESTED ☐ OTHER _____
12. WILL YOU RETURN TO OUR PATIENT CENTERED MEDICAL HOME SITE FOR YOUR HEALTHCARE NEEDS?
    ☐YES ☐NO

IF YOU WOULD LIKE ADMINISTRATIVE PERSONNEL TO CONTACT YOU ABOUT THIS SURVEY OR YOUR COMMENTS, PLEASE ADD YOUR NAME AND A DAYTIME TELEPHONE NUMBER AND WE WILL RETURN YOUR CALL, AS SOON AS POSSIBLE.

NAME: _____ TELEPHONE #: _____

**PLEASE FEEL FREE TO MAKE ANY COMMENTS ON THE BACK OF THIS FORM.

ANY INFORMATION THAT YOU PROVIDE ON THIS FORM WILL BE KEPT CONFIDENTIAL WITHIN THE ORGANIZATION.

Date: _____

Southwest Virginia Community Health Systems, Inc.

Date: _____