ADVANCED VISION SURGERY

Your Opinion Matters

Online Version

Thank you for choosing Advanced Vision Surgery Center for your recent procedure. We hope you are well on your way to recovery. To help us improve our care and service, please take a moment to fill out the brief survey below. All answers will remain confidential. Thank You!

On each item below, please rate your satisfaction level with Advanced Vision Surgery Center:	**Highly Satisfied**	**Satisfied**	**Neutral**	**Dissatisfied**	**Highly Dissatisfied**	**Not Applicable**
How satisfied were you with instructions and information from your Doctor?	5	4	3	2	1	NA
How satisfied were you with instructions and information from the Surgery Center?	5	4	3	2	1	NA
How satisfied were you with the service provided by the Surgery Center's Front Office Staff?	5	4	3	2	1	NA
How satisfied were you with the service provided by the Surgery Center's Preoperative Staff?	5	4	3	2	1	NA
How satisfied were you with the service provided by the Surgery Center's Operating Room Staff?	5	4	3	2	1	NA
How satisfied were you with the service provided by the Surgery Center's Anesthesia Staff?	5	4	3	2	1	NA
How satisfied were you with the service provided by the Recovery Staff at the Surgery Center?	5	4	3	2	1	NA
How satisfied were you with the discharge instructions you received from the Surgery Center?	5	4	3	2	1	NA
After returning home, did you experience any significant concerns? If Yes, please explain what happened:	Yes	No				
After returning home, did you receive a call from the Surgery Center's Staff after your surgery? If Yes, please share how the call helped:	Yes	No				
How satisfied were you with the patient care you received at the Surgery Center?	5	4	3	2	1	NA
How satisfied was your family member or friend with the comfort of the waiting area?	5	4	3	2	1	NA
Any additional comments or suggestions?						
How likely are you to recommend Advanced Vision Surgery Center to a family member or a friend?	Highly Likely	Likely	Neutral	Unlikely	Highly Unlikely	NA

Person Completing this survey ___Patient ___Spouse ___Parent ___ Family Member Date of Surgery:_____

Your surgeon for your surgery? _____ Patient Name: _____