Family Care Associates of Effingham
1106 N. Merchant
P.O. Box 665
Effingham, IL 62401
Phone (217) 342-7000
Fax (217) 342-7002

INSTRUCTIONS: Thank you for choosing Family Care Associates as your medical home. Please assist us in improving our services to you and other patients by completing the following questionnaire based on your most recent visit to our office.

Choose a response that best represents your thoughts in regards to the appointment/office. Also, please feel free to add any positive or negative comments.

When you complete the questionnaire, please email your responses to fcasurvey@familycareassociates.com, or return via mail to P.O. Box 665 Effingham, IL 62401.

Thank you!

Name (**optional**):_____ Age: _____ ☐ Male ☐ Female

Primary Insurance : ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Self-pay

Date of visit: _____ Was this your first visit to our office? ☐ Yes ☐ No

If someone other than the patient is completing this survey, please check here ☐

Please circle the primary reason for your visit:

Office Visit **Sport/School Physical** **Well Child Check** **Nurse Visit**

A. Access to Care	Very Poor	Poor	Satisfactory	Good	Excellent	N/A
1. Ease of scheduling your appointment	○	○	○	○	○	○
2. Courtesy of the person who scheduled your appointment	○	○	○	○	○	○
3. Our helpfulness on the telephone	○	○	○	○	○	○
4. Our promptness in returning your phone calls	○	○	○	○	○	○

Comments:

_____

_____

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B. During Your Visit	Very Poor	Poor	Satisfactory	Good	Excellent	N/A
1. Speed of the registration process	○	○	○	○	○	○
2. Courtesy of staff in registration area	○	○	○	○	○	○
3. Comfort and pleasantness of waiting area	○	○	○	○	○	○
4. Time spent in waiting room	○	○	○	○	○	○
5. Friendliness of nurse/medical assistant	○	○	○	○	○	○
6. Concern the nurse/medical assistant showed for your problem or condition	○	○	○	○	○	○
7. Time spent waiting in exam room before seeing your healthcare provider	○	○	○	○	○	○

Comments:_____

C. Your Care Provider	Very Poor	Poor	Satisfactory	Good	Excellent	N/A
1. Friendliness and professionalism of your care provider	○	○	○	○	○	○
2. Care, compassion, and respect your care provider showed for your concerns/worries	○	○	○	○	○	○
3. Explanations your care provider gave you about your problem or condition	○	○	○	○	○	○
4. Your care provider's effort to include you in decisions about your treatment	○	○	○	○	○	○
5. Information your care provider gave you regarding any medications or necessary follow-up	○	○	○	○	○	○
6. Degree to which your care provider talked to you in language you could understand	○	○	○	○	○	○
7. Amount of time your care provider spent with you at the visit	○	○	○	○	○	○
8. Likelihood of your recommending this care provider to others	○	○	○	○	○	○

Comments:_____

D. Personal Issues	Very Poor	Poor	Satisfactory	Good	Excellent	N/A
1. Convenience of our office hours	◯	◯	◯	◯	◯	◯
2. Our sensitivity to your needs	◯	◯	◯	◯	◯	◯
3. Our concern for your privacy	◯	◯	◯	◯	◯	◯
4. You are kept up-to-date on the status of referrals and/or lab or diagnostic imaging results	◯	◯	◯	◯	◯	◯

Comments:_____

_____

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_____

E. Overall Assessment	Very Poor	Poor	Satisfactory	Good	Excellent	N/A
1. Satisfaction with the office	◯	◯	◯	◯	◯	◯
2. Satisfaction with quality of medical care	◯	◯	◯	◯	◯	◯
3. Satisfaction with our staff and your care provider	◯	◯	◯	◯	◯	◯
4. Overall cheerfulness of our practice	◯	◯	◯	◯	◯	◯
5. Overall cleanliness of our practice	◯	◯	◯	◯	◯	◯
6. Likelihood of your recommending our practice to others	◯	◯	◯	◯	◯	◯

Comments:_____

_____

_____

_____

Would you like a manager/supervisor to contact you? ☐ Yes ☐ No

Phone Number _____

Thank you for choosing Family Care Associates as your medical home!