

# Four Leaf Clover, Inc.

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### PATIENT SATISFACTION SURVEY

Patient Name (Optional): \_\_\_\_\_

City, State: \_\_\_\_\_ Date: \_\_\_\_\_

It is our desire to provide you with the best quality services available. In order to help us maintain our high standards, please take a few moments to tell us how we are doing. Please complete this form and note the response that most closely matches your experience.

<b>REGARDING Four Leaf Clover, Inc.</b>	Extremely Satisfied	Satisfied	Dissatisfied	Extremely Dissatisfied
Services were provided in a timely manner				
My needs were met through the services/equipment provided				
The staff discussed my rights and responsibilities and financial obligations				
The staff informed me how to contact the office during and after hours				
I would utilize/recommend Four Leaf Clover, Inc. to my friends or family				
<b>REGARDING THE STAFF OF Four Leaf Clover, Inc.</b>	Extremely Satisfied	Satisfied	Dissatisfied	Extremely Dissatisfied
The representatives were courteous and professional				
Explanations and instructions offered by representatives were adequate				
All procedures/services were explained prior to performing them				
Equipment was clean and in good working order				
Was treated with respect				

#### Comments:

Please return the survey to Four Leaf Clover, Inc. in the envelope provided.

*Thank you for choosing Four Leaf Clover, Inc.*

