SOUTHEAST SPINE CENTER, LLC
PATIENT SATISFACTION SURVEY
(circle appropriate answer)

Post Procedure Patient Satisfaction Survey

1. What date was your procedure performed? ____________________

2. Have you ever had this procedure in a hospital? **Yes** **No**

3. If the answer to #2 is YES, which setting did you prefer? **Hospital** **Our Surgery Center**

4. Do you feel that you were given adequate pre-operative instructions? **Yes** **No**

5. Who explained the procedure to you (circle all that apply):

   Physician **Nurse** **Printed Material** **No One**

   Comments:____

6. Was the nursing staff courteous? **Yes** **No**

   Comments:____

7. Was the physician courteous? **Yes** **No**

   Comments:____

8. Did you find the Center's staff to be competent? **Yes** **No**

   Comments:____

9. Did you feel that you were given adequate post-procedure instructions? **Yes** **No**

   Comments:____

10. Were the payment procedures explained to you? **Yes** **No**

   Comments:____

12. If you ever need another procedure like this, would you come back to the SOUTHEAST SPINE CENTER, LLC? **Yes** **No**

   Please explain why or why not:____

Name (optional):____

RETURN COMPLETED FORM BY HAND DELIVERY OR VIA U.S. MAIL TO:
SOUTHEAST SPINE CENTER, 7450 SKIDAWAY ROAD, SAVANNAH, GA 31406