

### Patient Satisfaction Survey

You recently received Physical Therapy services from Guenther Physical Therapy member of the **Ohio Physical Therapy Network, Inc.** To improve our quality of care, we need to hear from you. Your participation is appreciated. Please complete this form on your discharge visit. **THANK-YOU!**

Directions: Please circle the number that best describes your experience with the care you received.  
 Strongly Disagree=1 Disagree=2 Neither Agree nor Disagree=3 Agree=4 Strongly Agree=5 No Opinion=6

**Circling #1 indicates a negative response <> Circling #5 indicates a positive response**

Strongly Disagree-----Strongly Agree

- |  |          |   |         |   |   |
|--|----------|---|---------|---|---|
| 1. My privacy was respected during my physical therapy care.....                                       | 1        | 2 | 3       | 4 | 5 |
| 2. My physical therapist was courteous.....  | 1        | 2 | 3       | 4 | 5 |
| 3. All other staff members were courteous.....   | 1        | 2 | 3       | 4 | 5 |
| 4. The clinic scheduled appointments at convenient times.....  | 1        | 2 | 3       | 4 | 5 |
| 5. I was satisfied with the treatment provided by my physical therapist.....                           | 1        | 2 | 3       | 4 | 5 |
| 6. My first visit for physical therapy was scheduled quickly.....                                      | 1        | 2 | 3       | 4 | 5 |
| 7. It was easy to schedule visits after my first appointment.....                                      | 1        | 2 | 3       | 4 | 5 |
| 8. I was seen promptly when I arrived for treatment.....   | 1        | 2 | 3       | 4 | 5 |
| 9. The location of the facility was convenient for me.....   | 1        | 2 | 3       | 4 | 5 |
| 10. Parking was available for me.....  | 1        | 2 | 3       | 4 | 5 |
| 11. My physical therapist understood my problem or condition.....                                      | 1        | 2 | 3       | 4 | 5 |
| 12. The instructions my physical therapist gave me were helpful.....                                   | 1        | 2 | 3       | 4 | 5 |
| 13. I was satisfied with the overall quality of my physical therapy care.....                          | 1        | 2 | 3       | 4 | 5 |
| 14. I would recommend this facility to family or friends.....  | 1        | 2 | 3       | 4 | 5 |
| 15. I would return to this facility if I required physical therapy care in the future..                | 1        | 2 | 3       | 4 | 5 |
| 16. Do you feel that your treatment was terminated because of a limitation in your insurance coverage? | _____Yes |   | _____No |   |   |