

Active Medical LLC

120 Prosperous Place, Ste 103 Lexington, Ky 40509

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Exemplary Provider Satisfaction Measure ©

Patient: _____ **Date of Service:** _____

New **Existing Equipment:** _____

Access, Delivery and Service

	Yes	No	NA
1. Equipment/Supplies was delivered in a timely manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Equipment/supplies was ready for patient use upon delivery.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Received and understood instructions on proper application and use of equipment/supplies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feel confident to operate/use equipment/supplies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Received info on my Rights & Responsibilities, complaint process, billing, contact numbers, and reasons to notify the equipment/supply company.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Response to my questions, problems, concerns were addressed in a timely manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Satisfied with the equipment or supplies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Satisfied with the service. Would recommend to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Employee _____

Date of survey _____

One copy to patient chart, one copy to TCT Corporate office monthly.