



DIGESTIVE HEALTH ASSOCIATES of Cheyenne

Please tell us your opinion about the service you received at our Facility.
Thank You.

Name (optional): _____ Date _____

	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
A. Your Appointment:						
1. Ease of making an appointment	5	4	3	2	1	N/A
2. The Ease of the Check in Process	5	4	3	2	1	N/A
3. Waiting Time in reception area	5	4	3	2	1	N/A
B. Our Staff:						
1. Friendliness of the Front Desk Staff	5	4	3	2	1	N/A
2. Caring/Concern of medical staff (Nurse, MA)	5	4	3	2	1	N/A
5. Helpfulness of the Scheduling Staff	5	4	3	2	1	N/A
C. Our Communication with you:						
1. Your phone calls are answered within one business day	5	4	3	2	1	N/A
2. Your test results were reported in a timely manner	5	4	3	2	1	N/A
3. Your ease in obtaining prescription refills	5	4	3	2	1	N/A
D. Your Visit with the Provider:						
1. Waiting time in the exam room	5	4	3	2	1	N/A
2. Takes time to answer your questions	5	4	3	2	1	N/A
4. Instructions regarding medication/follow up care	5	4	3	2	1	N/A

What Provider did you see today: (circle) Dr. Kranz Dr. McRae Dr. Buran Dr. Horner Dr. Skrove

Additional Comments:

Thank you in advance for your feedback! We use your feedback to help us improve your experience. If you would like to give us permission to use your comments and name on our website please sign and date:

Signature: _____ **Date:** _____