

Customer Survey

Dear Physician or Referring Coordinator,

PremiereScan constantly strives to provide quality patient care and physician service that you can depend on. In our effort to monitor and improve our service, we seek feedback from those who can best evaluate our performance – our patients and our referring offices.

Please take a few minutes to let us know about your experience with PremiereScan. We are interested in your candid opinion, whether it is positive or negative. Your feedback will help us provide better service for you, your patients and our community in the future. Thank you for your assistance. **Please fax the completed survey to 408-984-7225.**

1. What is your scheduling preference with us?

Patient to schedule Call directly to schedule Fax scheduling

2. Is your office interested in the option to schedule appointments online? Yes No

3. PremiereScan offers MRI/CT scans on CDs, and/or online viewing for reports and scans; would you be interested in finding out more about these services? Yes No

4. PremiereScan offers key/spot images with all reports. How important is this to your clinic?

Very Important Somewhat Important Not Important

In answering the following questions please rate your answers according to the following scale:

1 – Poor 2 – Fair 3 – Good 4 – Excellent

- | | | | | |
|--|---|---|---|---|
| 5. How would you rate your experience of scheduling an appointment? | 1 | 2 | 3 | 4 |
| 6. Are your patients able to schedule an exam with us in a timely manner? | 1 | 2 | 3 | 4 |
| 7. How is your office treated by our staff? | 1 | 2 | 3 | 4 |
| 8. How would your patients rate the care they received at our center? | 1 | 2 | 3 | 4 |
| 9. How would you rate our timeliness in getting your patient's reports/results to your office? | 1 | 2 | 3 | 4 |
| 10. How would you rate our phone response time and phone hold times? | 1 | 2 | 3 | 4 |
| 11. How are special request (i.e. STAT exams, faxed reports, etc.) accommodated? | 1 | 2 | 3 | 4 |
| 12. How does your physician(s) rate the quality of our images? | 1 | 2 | 3 | 4 |
| 13. How would your physician(s) rate the exam reports? | 1 | 2 | 3 | 4 |
| 14. Do you feel our Radiologists communicated with your office/physician effectively? | 1 | 2 | 3 | 4 |
| 15. Is our Marketing team meeting your needs? | 1 | 2 | 3 | 4 |
| 16. How would you rate our pre-authorization services? | 1 | 2 | 3 | 4 |
| 17. What PPOs/HMOs would you like to us start accepting? | 1 | 2 | 3 | 4 |

Additional Comments:

Your Name: _____

Physician's Name: _____

Address: _____

Phone: _____ **Fax:** _____