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SXM SYMPTOM MEDICINE
Pain Medicine, Palliative Care, Anesthesia

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FIVE MINUTE PROVIDER HEALTH CARE SURVEY

Our goal is to provide the best care and services possible. Please complete the survey, and make comments as you wish. After you have completed the survey, return it via fax or mail. Thank you for completing the survey.

How did you learn about the clinic?

Advertisement Mailer Brochure Web Site Health Care Provider _____

What service do you believe is the most helpful to your patients? (Circle all that apply)

Pain Management Pain Injection & Procedures Anesthesia Medication Management
Symptom Management Hospice & End of Life Symptoms Palliative Care Second Opinion
Cancer Pain & Symptoms

Were clear directions given regarding appointment requirements and pre-authorization? YES NO

Were your phone calls returned within 24 to 48 hours of leaving a message? YES NO

When you call the clinic do you how was the call handled?

Voice mail leave a message Hang-up and call back Speak to a receptionist?

Were you called and informed that a patient referral was received? YES NO

Did the staff appear and act in a professional manner? YES NO

Did you your patient receive an appointment within a reasonable amount of time? YES NO
If no, what do you think caused the delays?

Insurance Preauthorization/Approval Clinic Paperwork Referral from Doctor
Medical Records Appointment Availability

Did you feel that the medical assistant informed you as to why there were delays? YES NO

Does the clinic staff answer questions or takes information to get your questions answered? YES NO

Please describe any concerns/suggestions you have.

What do you think would improve your experience at the Clinic?