

## Legends Medical Supplies PATIENT SATISFACTION SURVEY

Date: \_\_\_\_\_

Dear Patient,

It is our desire to provide you with the best quality services available. In order to help us maintain our high standards, please take a few moments to tell us how we are doing. Please complete this form and mail it back to us. Thank you.

Was your equipment (and supplies if applicable) delivered on time?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was the equipment (and supplies if applicable) delivered / dispensed accurately?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was the training and consultations effective in educating you or your caregiver on your equipment (and supplies if applicable)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was the educational materials and instructions provided adequate to educate you or your caregiver on the product(s) provided?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was the company staff courteous and helpful?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Was your financial responsibilities explained to you?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Did you receive advice or help when requested?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Did the services provided make a positive impact on the outcome of your care?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Would you recommend our services to friends and family?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Did the services provided meet your needs and expectations?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

COMMENTS (OPTIONAL)

Signature (optional) \_\_\_\_\_

COMPLETED FORM CAN BE EMAILED TO: [Survey@LegendsMedical.com](mailto:Survey@LegendsMedical.com)  
OR MAILED TO: Legends Medical Supplies 25329 Budde Rd #203, Spring, TX 77380