# Provider Satisfaction Survey

JEFFERSON RADIOLOGY
an affiliate of MEDNAX

Practice Name: _____ Provider Name: _____ May we contact you? yes ☐ no ☐

Instructions: Please send your completed survey to Dan Cloyd, Senior Manager of Business Development
Fax: 860-783-5797 | Email: dcloyd@jeffersonradiology.

Please indicate the occupation of the person completing this survey.

☐ Physician ☐ PA ☐ APRN
☐ RN ☐ Medical Assistant ☐ Office Manager
☐ Ref. Coordinator ☐ Other

Medical Specialty: _____

| | VERY SATISFIED | SATISFIED | NEUTRAL | DISSATISFIED | VERY DISSATISFIED |
|---|---|---|---|---|---|
| 2. How satisfied are you with the **accessibility of Jefferson Radiology's Radiologists?** | ◯ | ◯ | ◯ | ◯ | ◯ |
| *Comments regarding accessibility:* | | | | | |
| 3. How satisfied are you with the **turnaround time** of radiology results? | ◯ | ◯ | ◯ | ◯ | ◯ |
| *Comments regarding turnaround time:* | | | | | |
| 4. How satisfied are you with Jefferson Radiology's **quality of images produced**? | ◯ | ◯ | ◯ | ◯ | ◯ |
| *Comments regarding quality of images:* | | | | | |
| 5. How satisfied are you with Jefferson Radiology's **quality of reporting**? | ◯ | ◯ | ◯ | ◯ | ◯ |
| *Comments regarding quality of reporting:* | | | | | |
| 6. How satisfied are you with Jefferson Radiology's **responsiveness to service issues**? | ◯ | ◯ | ◯ | ◯ | ◯ |
| *Comments regarding responsiveness to service issues:* | | | | | |
| 7. How satisfied are you with the **scheduling of your patients through the customer care center**? | ◯ | ◯ | ◯ | ◯ | ◯ |
| *Comments regarding scheduling with the customer care center:* | | | | | |
| 8. If applicable, how satisfied are you with Jefferson Radiology's **pre-authorization process for MRs and CTs?** | ◯ | ◯ | ◯ | ◯ | ◯ |
| *Comments regarding the pre-authorization process for MRs and CTs:* | | | | | |

9. Is Jefferson Radiology your preferred imaging provider? Yes ◯ No ◯

*If no, please indicate your preferred provider:*