



Comprehensive Neurology and Sleep Medicine, P.A.

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We need your help to improve our services.

Your feedback offers valuable insight regarding the care and comfort of our patients. Based on the results of past surveys, we have implemented many changes in our practice.

Thank you in advance for taking the time to complete this confidential questionnaire about the care you have received.

Before your appointment:

Please mark your response (from 1-Strongly Disagree to 5-Strongly Agree) to the following questions:

When scheduling my appointment, the phone staff was courteous and helpful.	1	2	3	4	5
I was able to schedule an appointment at the time I needed.	1	2	3	4	5
The information I received prior to my visit was helpful.	1	2	3	4	5

During your appointment:

Please mark your response (from 1-Strongly Disagree to 5-Strongly Agree) to the following questions:

I was greeted and registered promptly.	1	2	3	4	5
The registration staff was courteous and helpful.	1	2	3	4	5
The forms I was asked to complete were easy to understand.	1	2	3	4	5
I was in the outer waiting room for a reasonable amount of time.	1	2	3	4	5
I waited in the examination room for a reasonable amount of time.	1	2	3	4	5
My healthcare provider was compassionate.	1	2	3	4	5
My healthcare provider gave me enough time to ask questions.	1	2	3	4	5
My healthcare provider sufficiently answered my questions.	1	2	3	4	5
My diagnosis was adequately explained.	1	2	3	4	5
I felt involved in designing my treatment plan.	1	2	3	4	5
I understand the treatment plan and next steps.	1	2	3	4	5
I know the process to ask follow-up questions after my appt.	1	2	3	4	5
I was able to easily set-up my next appointment.	1	2	3	4	5

General:

Please circle the appropriate response:

Did we obtain any authorizations or pre-certifications necessary?	Yes	No	N/A
Did we handle your payment properly?	Yes	No	N/A
Are your billing statements easy to understand?	Yes	No	N/A
Were your phone calls returned within 24 hours?	Yes	No	N/A
Did you visit our website before or after your appointment to learn more?	Yes	No	
Will you recommend us to others?	Yes	No	

Please use the space provided to answer the final questions:

What did you like best about our office staff, doctor or nurse? Is there someone you'd like to thank for being especially helpful or caring?

How can anyone you interacted with improve? Is there a staff member that needs to address any issues that were not dealt with to your satisfaction? (All survey information will be confidential and no names will be released to the staff or providers.)

Would you like to be contacted to discuss any concerns? Yes No

If yes, please provide us information to contact you:

Name: _____

Phone: _____

Email: _____

What is your preferred method of method of contact? (circle) Phone E-mail

Would you like to receive further information about:

_____ Neurological services

_____ Sleep diagnoses and care

_____ Diagnostic Testing