



Patient Satisfaction Survey

Dear Patient:

Please rate the service(s) provided to you by Advanced Care Scripts using a scale from 1-5, with 5 being the highest score.

Name (optional): _____

Date: _____

	Poor 1	Below Average 2	Average 3	Above Average 4	Excellent 5
1.) Was the medication you received correct?					
2.) How accurate was the information on the prescription label?					
3.) Was your prescription delivered on time?					
4.) Was the invoice/statement for your prescription what you expected?					
5.) Please rate your experience with your:					
a. Patient care specialist					
b. Nurse					
c. Pharmacist					
d. Billing/reimbursement specialist					
6.) Were you told who to call if you had any problems with your prescription?					
7.) Did the services provided meet your needs and expectations?					
8.) How likely would you recommend Advanced Care Scripts to others?					
9.) How was your overall experience with Advanced Care Scripts?					

Please include any comments or suggestions on how we can improve our services below. You may also contact our Patient Concern line with any questions, comments, or concerns you may have at: (866) 944-9511.

Thank you for your assistance.
Advanced Care Scripts