**PATIENT SATISFACTION SURVEY**

***Please answer the following questions with a number between 1 and 5, with 5 being best and 1 being worst.***

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| 1. | Overall, how satisfied or dissatisfied were you with your visit to RCCA-CJD? |  |  |
|  |  |  |  |
| 2. | How do you rate the level of caring at RCCA-CJD? |  |  |
|  |  |  |  |
| 3. | How satisfied are you with the level of service you received from the staff at RCCA-CJD? |  |  |
|  |  |  |  |
| 4. | How well was your exam explained to you?  |  |  |
|  |  |  |  |
| 5. | How satisfied are you with the quality of the care you have received here? |  |  |

**What quote would you use to best describe your experience with RCCA’s Central Jersey Division?**

**Would you recommend RCCA’s Central Jersey Division to a friend or a family member? Why?**

**Any other comments?**

**Authorization and Release**

I hereby irrevocably authorize the Central Jersey Division of Regional Cancer Care Associates (hereinafter referred to as “RCCA-CJD”) to copy, exhibit, publish or distribute my comments for purposes of publicizing RCCA-CJD’s programs or for any other lawful purpose. These statements may be used in printed publications, multimedia presentations, on websites or in any other distribution media. I agree that I will make no monetary or other claim against RCCA-CJD for the use of the statement. In addition, I waive any right to inspect or approve the finished product, including written copy, wherein my likeness or my testimonial appears.

I hereby hold harmless and release RCCA-CJD from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I have read the authorization and release information and give my consent for the use as indicated above.

|  |  |
| --- | --- |
| Print Name: |  |
| Signature: |  |
| Date: |  |