NeuroScience Imaging Center
Patient Survey

Please complete and fax to 334-286-3165
You may also return by mail to:
2065 East South Blvd Suite 102
Montgomery, Alabama 36116

Date: _____________________________________________

Referring Physician’s Name: _________________________________

Please check which examination you will be receiving:

☐ MRI
☐ CT

Please circle one of the answers below:
1. Speed and ease of admission process.
   Excellent  Good  Fair  Poor

2. Courtesy of person who admitted you.
   Excellent  Good  Fair  Poor

3. Was your appointment prompt/ were you notified if appointment time was delayed?
   Excellent  Good  Fair  Poor

4. Courtesy of technician performing your exams.
   Excellent  Good  Fair  Poor

4. How did staff respond to concerns, needs, or complaints voiced by you or your family during your call(s) or visit(s)?
   Excellent  Good  Fair  Poor

5. Overall quality of your experience while you were cared for at NIC.
   Excellent  Good  Fair  Poor

Please give us your comments:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________