SIGNATURE REQUIRED
YOU MUST COMPLETE THIS PAGE AND RETURN

Bridgewater HEALTH SUPPLIES

EXEMPLARY PROVIDER SATISFACTION MEASURE©

Patient Name:_____ Patient Phone:_____

◯New ◯Existing Equipment:_____ Date Received:_____
(equipment received)

ACCESS, DELIVERY AND SERVICE	**YES**	**NO**	**N/A**
1. Equipment/Supplies was delivered in a timely manner.	◯	◯	◯
2. Equipment/supplies was ready for patient use upon delivery.	◯	◯	◯
3. Received and understood instructions on proper application and use of equipment/supplies.	◯	◯	◯
4. Feel confident to operate/use equipment/supplies.	◯	◯	◯
5. Received info on my Rights & Responsibilities, complaint process, billing, contact numbers, and reasons to notify the equipment/supply company.	◯	◯	◯
6. Response to my questions, problems, concerns were addressed in a timely manner.	◯	◯	◯
7. Satisfied with the equipment or supplies.	◯	◯	◯
8. Satisfied with the service. Would recommend to others.	◯	◯	◯

Comments: _____

_____

_____

Employee: _____
(Bridgewater represenatative who helped you- if applicable)

Signature: _____ Survey Date: _____

Please sign above and mail back to Bridgewater Health Supplies in the included envelope - or at the address below if supplied envelope has been lost or damaged:

Bridgewater Health Supplies
LLC 116A South Street
Oyster Bay, NY 11771

To digitally sign all "signature required" documents in this packet, please visit:
www.bridgewaterhealthsupplies.com/eSign/