

**Review of Care Experience Disclosure**

Patient Name: \_\_\_\_\_  
First Name Only

Visit Date \_\_\_\_\_

	Stars					Remarks (Use additional sheets if needed)
	1	2	3	4	5	
<b>Scheduling Appointment</b>						
<b>Front Desk</b>						
<b>Wait Time</b>						
<b>Screening and Testing</b>						
<b>Dr. Peddada's Care</b>						
<b>Overall Experience</b>						

Please drop off the completed form at the front desk, fax to (334) 521-0043 or email to [Adminstrator@SiteforSight.NET](mailto:Adminstrator@SiteforSight.NET).

We appreciate your feedback. Please let us know what we are doing right and if we need to improve in any area. We may also utilize this information (page 1) in marketing without using any personal information other than your first name.

\_\_\_\_\_  
**Patient / Authorized Person signature**

\_\_\_\_\_  
**Today's date**