The P.A.T. Center

The P.A.T. (People Advocating Transition) Center CO; The PAT Center II
DBA The P.A.T. Center
6210 Baseline Road; Little Rock, AR 72209 *** Phone: 501-265-0302 Fax: 501-265-0300
(Locations: Little Rock, North Little Rock, Pine Bluff & Forrest City)

Client Satisfaction Questionnaire

Please check one: ☐Client-Adult ☐Client-Child/Adolescent Date: ___________________________

Please select the provider you last saw that this satisfaction survey pertains to:
☐Psychiatrist ☐Therapist/MHP ☐QBHP ☐Office Support Staff

Check the box to show how much you agree or disagree with each statement. Your answers will remain anonymous unless you choose to identify yourself.

Please use the following scale: **1** = Strongly Disagree **2** = Disagree **3** = Agree **4** = Strongly Agree **N/A** – Does not apply

	1	2	3	4	NA
1. I am treated with dignity and respect.					
2. The program or treatment plan focuses on recovery.					
3. My grievances or concerns were addressed.					
4. I was given the opportunity to make informed choices about my treatment, medications, and other care options.					
5. I feel the fees for service are affordable.					
6. The location of the office is convenient.					
7. The hours for appointments are convenient.					
8. I am satisfied with the results of my treatment.					
9. The wait time for my first appointment and follow-up appointments was reasonable.					
10. Telephone calls are returned in a timely manner.					
11. When I have a crisis, I receive a response in a timely manner.					
12. Information and materials are provided in my preferred language or communication style.					
13. I feel that I have been given hope for my future.					
14. Staff at this agency respect and understand my unique needs, values, beliefs, actions, customs, communication styles, and identity, considering my racial, ethnic, religious, and/or social background or sexual orientation.					
15. I am satisfied with using telehealth or telemedicine for my treatment.					
16. The services I received through telehealth/telemedicine met my needs.					
17. The services I received through telehealth/telemedicine met my needs are equal to or better than those provided face to face					
18. I am satisfied with the psychiatric services (example: medications) I receive.					
19. I am satisfied with the therapy (individual, family, group) services I receive.					
20. I am satisfied with the services provided by the QHBP staff.					

Overall Satisfaction: Using a scale from 0 to 10, where 0 is the worst mental health care possible and 10 is the best mental health care possible, please circle the number that best rates your mental health services since your last visit. **1 2 3 4 5 6 7 8 9 10**

Comments:____
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Office Use Only: Year: ______________________ Quarter: ___1 ___2 ___3 ___4 **Staff doing phone survey (if applicable)**: ______________

Updated 12/2019; Reviewed/Updated: 7/2020; 7/2021; 7/2022; Review 7/2023; Updated 12/2024; Updated 3/6/2024

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The PAT Center II, Inc.

Stakeholder Questionnaire

Check one: ☐Parent/guardian of child/adolescent ☐Family member of adult client ☐Referring Agency ___________________

Date: ___________________________

Please select the provider you last saw or encountered that this satisfaction survey pertains to:
☐Psychiatrist ☐Therapist/MHP ☐QBHP ☐Office Support Staff

Check the box to show how much you agree or disagree with each statement. Your answers will remain anonymous unless you choose to identify yourself.

Please use the following scale: **1** = Strongly Disagree **2** = Disagree **3** = Agree **4** = Strongly Agree **N/A** – Does not apply

	1	2	3	4	NA
1. The information I received from the program met my needs.					
2. The information I received from the program was useful in my decision-making					
3. I received information from the program in a timeframe that met my needs					
4. I am satisfied with the opportunities available to interact with the treatment team serving my family member or client.					
5. I am satisfied with the services my family member or client received from the program.					
6. I would recommend this program to others.					
7. I would refer again to this program.					
8. I am satisfied with the timeframe for admission to services for the person receiving services or referred.					
9. I am satisfied with the communication mechanism to coordinate care for persons served.					
10. I am satisfied with using telehealth or telemedicine for my child/adolescent or client.					
11. The services I received through telehealth/telemedicine met my needs.					
12. The services I received through telehealth/telemedicine will positively impact my child/adolescent or client.					
13. I am satisfied with the psychiatric services (example: medications) received.					
14. I am satisfied with the therapy (individual, family, group) services receive.					
15. I am satisfied with the services (school visits, home visits, resources) provided by the staff.					

Overall Satisfaction: Using a scale from 0 to 10, where **0** is the worst mental health care possible and **10** is the best mental health care possible, please circle the number that best describes your experience with mental health services your child/adolescent/client receives.

1 2 3 4 5 6 7 8 9 10

Comments:____
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Office Use Only: Year: ________________________ Quarter: ___1 ___2 ___3 ___4
Name of The P.A.T. Center Staff doing phone survey (if applicable): ____

Updated 12/2019; Reviewed/Updated: 7/2020; 7/2021; 7/2022; Review 7/2023; Updated 12/2024