Patient Feedback Form

Life sounds brilliant.

Patient Information

Name of Patient: _____

Age of Patient: _____ Date of first telehealth appt: _____ Date of fitting: _____

Make / model of hearing aids: _____

Remote Care Experience

1. What device is your patient using for Signia TeleCare? (Check ALL that apply)

   ☐ Smartphone ☐ Tablet ☐ iOS device ☐ Android device

2. How satisfied are you with the technical quality of Remote Care, for this patient? (Check ONE box)

   ☐ Satisfied ☐ Neutral ☐ Dissatisfied

3. Did you receive the correct hearing screening information, for this patient? (Check ONE box)

   ☐ Yes ☐ No

4. How satisfied are you with the ordering process, for this patient? (Check ONE box)

   ☐ Satisfied ☐ Dissatisfied (please explain)
   ☐ Neutral

5. Was the packaging of the hearing instruments (and contents) correct, for this patient? (Check ONE box)

   ☐ Yes ☐ No

6. Did the hearing instruments arrive fully charged, for this patient? (Check ONE box)

   ☐ Not applicable ☐ Yes ☐ No

7. Did the coupling (dome/receiver) arrive properly assembled, for this patient? (Check ONE box)

   ☐ Yes ☐ No

8. How satisfied are you with the overall, end-to-end Remote Care, for this patient? (Check ONE box)

   ☐ Satisfied ☐ Neutral ☐ Dissatisfied

9. Please provide any additional feedback that may be beneficial, to Signia, to improve this process:

Please submit the completed form to SigniaRemoteCare@signiausa.com