Holicki Eye Centers & Optical

Share YOUR Testimony!

At Holicki Eye Centers, we appreciate you placing your trust in us regarding your vision and eye care needs. Please take a moment to let us know how your experience was and share any ideas as to how we could improve any part of the process. We thank you for your time and appreciate your candid remarks.

YOUR INFORMATION

Please, Print Your Name: _____
(First Name) (Last Name)

Date:_____ **Age:**___ ☐**Prefer not to say**

Where do you live? _____

When did you first start coming to Holicki Eye Centers? _____

How did you hear / Who referred you to this office? _____

Which Doctor did you see? (Please circle all that apply)

Dr. Holicki, D.O. | Dr. Smith, O.D. | Dr. Emerson, O.D.

Explain to us what was your particular condition? (i.e. Cataracts, Age-Related Macular Degeneration, Diabeties, Blurry vision, Loss of Vision, Glaucoma.)?

_____

_____

_____

Any staff member you would like to mention? (Positive or negative, we would like to know.)

_____

_____

_____

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Did you receive helpful and adequate information? (Were all your questions answered and concerns addressed?)

_____

_____

_____

When it comes to eye care you received at Holicki Eye Centers & Optical provided what stands out the most? (i.e. amount of time spent with you, atmosphere, quality of care, expertise, chair side manner, etc.)?

_____

_____

_____

How did the Doctors at Holicki Eye Centers help you?

_____

_____

_____

What would you say to a friend / family member who is looking for ocular health care?

_____

_____

_____

Would you recommend this office to friend / family member?

☐Yes ☐No ☐Maybe/Unsure

How many stars would you rate Holicki Eye Center & Optical? (Please, circle)

1 2 3 4 5

Do you have any advice or suggestions on how Holicki Eye Centers & Optical can improve their service?

_____

_____

_____

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Could you please write a few sentences in your own words about your overall experience?

_____

_____

_____

_____

_____

Additional Comments:

_____

_____

_____

Can we use your name and testimonial in our advertising? ☐Yes ☐No

Signature: _____ ***Date:*** _____

Thank you again for your time. This information is very helpful to all of us.

THANK YOU FOR SHARING YOUR EXPERIENCE!

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Patient Testimonial Release Consent

Purpose of Consent: By signing this form, you are consenting to the Holicki Eye Centers and Optical's (HECO), use and disclosure of the information in your testimonial and acknowledgement that the testimonial may be distributed to the public.

Right to Revoke: You have the right to revoke this Release at any time by giving us written notice of your revocation and submitting it to the Contact Person listed below. Please understand that revocation of this Release will not affect any action that Holicki Eye Centers and Optical took in reliance on this Release before receiving you revocation.

CONSENT TO RELEASE

I hereby authorize Holicki Eye Centers and Optical to use my testimonial and any information in the testimonial in its public relations efforts. I understand and approve the disclosure by HECO of testimonial information to the media and other individuals and entities that may be involved in HECO's public relations efforts.

I understand that I am providing the testimonial information to HECO and that my treating physician will not be providing any information, including private health information in my medical records, the confidentiality of which may be protected by federal and state statutes and regulations, including, Health Insurance Portability and Accountability Act (HIPAA).

I waive the right of prior approval and hereby release HECO from all claims for damages of any kind based on the use of my testimonial or information in the testimonial.

I am of legal age and freely sign this release, which I have read and understood.

_____
Signature

_____
Print Name

_____
Date

Please send the completed form to:

Holicki Eye Centers and Optical

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