

ASSOCIATED MEDICAL, INC.

Dear Patient,

We greatly appreciate the opportunity to provide you with the VascuTherm Cold Compression, DVT therapy system and sincerely hope that your recovery is right on schedule. The VascuTherm system is relatively new in CT, MA, and NY and has thus far been met with high patient satisfaction. Please offer your feedback and experience so that we may improve our process, service, and equipment/wrap design. As a growing company, constructive criticism is invaluable to us, and every idea and comment gets considered. If you feel that the VascuTherm helped you and that others would benefit from it, please tell us as your review may be shared with the referring surgeon or staff and can impact future decision making on this device and other new technologies. We're passionate about fast recoveries, pain management and orthopedic innovations. Please help us by completing and returning your review.

For those interested, we are delighted to share your story, email, or letter on our website. If you'd like for us to do this, please include your permission for us to post. Also, a number of patients are sharing short video responses for web-posting and patient-to-patient reviews. If you would be open to sharing your experience via a short 1-2 minute video, call/email to discuss or just shoot it with your cell phone / camera, send us a link, and we'll put it on our website.

	Very Dissatisfied			Very Satisfied	
	1	2	3	4	5
Friendliness, professionalism and courtesy of our staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quality of the initial setup or in-service	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Completeness of the clinical information and instructions provided	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understanding how to use the VascuTherm and for how long	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Our availability, support, and callback response times	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clinical use or help to you on pain and inflammation management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How satisfied were you with the VascuTherm's assistance to your recovery?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall, how did you feel about the quality of care you received?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Unlikely			Likely	
Would you recommend Associated Medical's services to others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If you required another orthopedic surgery, would you request the VascuTherm or products of Associated Medical again?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel that you took less pain medication while using this device?	<input type="radio"/> Yes		<input type="radio"/> No		
Did you have any allergic reaction or sensitivity to the medications?	<input type="radio"/> Yes		<input type="radio"/> No		
If you recall, please tell us how many days you took prescription pain meds	Days 0, 1, 2, 3, 4, 5, 6, 7, 10, 14, 21, __				

Please share anything you wish. Tell us what you liked, where we can improve, or anything you want your surgeon or provider to know about your experience with us or about the VascuTherm's use in your recovery.

Name (optional) _____ Surgeon (optional) _____

Do we have your permission to include your response in our marketing? (this is helpful if okay) Yes No