

WATER WORKS FUNCTIONAL ASSESSMENT

Name: _____

Date: _____

Please mark the line of the statement that best describes how you feel for each of the sections below.

SECTION # 1 PAIN

- _____ Pain does not limit my activities at all.
- _____ My activities are mildly limited by pain.
- _____ My activities are moderately limited by pain.
- _____ My activities are very limited by pain.
- _____ I am unable to do any activity due to pain.

SECTION # 2 RISING FROM SITTING

- _____ I have no problem rising from sitting (including low chairs, toilet seats, car seats).
- _____ It is not as easy as it should be getting up from sitting but I can do it myself.
- _____ I need a little help from someone to get up from sitting.
- _____ I need much help from someone else to get up from sitting.
- _____ I have pain getting up from sitting.

SECTION # 3 DRESSING AND BATHING

- _____ I can bathe and dress myself without any difficulty.
- _____ I can bathe and dress myself but it takes more time than it should.
- _____ I need some help but do most of the dressing and bathing myself.
- _____ I need much help to bathe and dress.
- _____ I am unable to help with my dressing and bathing.

SECTION # 4 WALKING

- _____ I can walk briskly as far as I want to go without an assistive device (e.g. cane, walker, help of another)
- _____ I can walk slowly almost any distance I need to without any assistance.
- _____ I can walk about a block before I have a problem but much slower than I should be.
- _____ I can walk around outside if I am careful.
- _____ I can walk within my home without a problem, but walking outside is limited.
- _____ I have problems walking in my house.
- _____ I am afraid of falling.

SECTION # 5 STEPS

- _____ I can walk up and down a flight of stairs without limitations.
- _____ I can walk up and down a flight of stairs but it is a little difficult for me or causes me some pain.
- _____ I can walk up and down a flight of stairs but it is very difficult.
- _____ I can walk up and down a few steps but no more.
- _____ I have some difficulty stepping up and down curbs.
- _____ I am fearful of falling on steps and curbs and need help.

SECTION # 6 LIFTING OR CARRYING

- _____ I can lift and carry all the items I need to without a problem.
- _____ I have some trouble carrying and lifting some items.
- _____ I can lift and carry only very light objects.
- _____ I have pain with lifting or carrying objects.

SECTION #7 KNEELING AND SQUATTING

- _____ I have no problem getting up off of the floor.
- _____ I could get up from the floor only if I had something nearby to pull myself up with.
- _____ I could kneel on the floor and get up without a problem.
- _____ I can squat down to pick something up off of the floor without a problem.
- _____ I could pick something up from the floor only with a great deal of difficulty.
- _____ I can not pick objects up off of the floor.

SECTION #8 TRAVELING

- _____ I can get in/out of cars and drive as long as I need to without any problem.
- _____ I can get in/out of cars without difficulty but can only drive limited distances.
- _____ I have some difficulty getting in/out of cars but I do it myself.
- _____ I need a little help to get in/out of cars.
- _____ I need a great deal of help to get in/out of cars.

SECTION #9 RECREATION AND SOCIAL ACTIVITIES

- _____ I am able to engage in all of my recreational and social activities without limitations.
- _____ I am able to engage in my recreational and social activities with a few limitations.
- _____ My limitations restrict me from my energetic recreational and social activities.
- _____ My limitations restrict me from recreational and social activities and I do not go out often
- _____ I cannot do any recreational or social activities due to my problems.

SECTION #10 DOMESTIC AND JOB ACTIVITIES

- _____ I can do as much work as I want.
- _____ I can do most of my usual work (in and out of the home), but not all.
- _____ My work in and out of home had had to be modified.
- _____ I need help with household chores.
- _____ I am unable to do any work at this time.

PLEASE LIST BELOW THOSE ACTIVITIES THAT YOU MOST WISH TO SEE IMPROVE:

**WATER WORKS TOTAL REHAB
MEDICAL QUESTIONNAIRE**

**Please complete this questionnaire prior to beginning your initial evaluation and treatment program.
Please do not leave any spaces blank. If the question does not apply, please write N/A.
Thank you.**

NAME _____ SSN ____/____/____

BIRTHDATE _____ AGE _____ MARITAL STATUS _____

LOCAL ADDRESS _____ CITY _____ STATE _____ ZIP _____

LOCAL PHONE _____

OUT OF STATE ADDRESS _____ CITY _____ STATE _____ ZIP _____

OUT OF STATE PHONE _____

Place of Employment _____ Occupation _____ Business Ph# _____

Local contact name and phone # _____

Emergency contact name and phone # _____

Spouse's Place of Employment _____ Ph# _____

Spouse's Date of Birth ____/____/____ Spouse's SSN ____/____/____

Person Responsible for payment _____ SSN ____/____/____

Address _____

Home Ph# _____ Business Ph# _____

Insurance Co _____ ID# _____ Group# _____

2nd Insurance Co _____ ID# _____ Group# _____

Family doctor _____ Referring doctor _____

How did you hear about Water Works Total Rehab? _____

ARE YOU CURRENTLY RECEIVING OR HAVE YOU HAD IN THE LAST THREE MONTHS, SERVICES FROM A HOME HEALTH AGENCY UNDER AN ACTIVE HOME HEALTH PLAN OF CARE? _____

If yes, please state the name of the agency. _____

Please place a checkmark () if you presently have or have a history of any of the following.
Please explain the item you have checked in the space available.

- ____ HAVE YOU FALLEN IN THE PAST 3 MONTHS _____
- ____ HEART _____
- ____ SURGERY/PACEMAKER _____
- ____ HEART DISEASE/CHESTPAIN/CARDIAC PRECAUTIONS _____

HIGH OR LOW BLOOD PRESSURE _____ IS IT CONTROLLED? _____
 RESPIRATORY DISEASE/SHORTNESS OF BREATH/USE OXYGEN _____
 CIRCULATION PROBLEMS _____
 SURGERY (WHAT/WHEN?) _____
 JOINT REPLACEMENT(S) _____
 SEIZURES _____ LAST ONE? _____
 DIABETES _____ CONTROLLED? _____
 STROKE _____ WHEN? _____
 FAINTING OR DIZZINESS _____
 INFECTION _____
 OPEN CUTS/WOUNDS/INCISIONS _____
 MULTIPLE SCLEROSIS _____
 CONDITION THAT MAKES YOU HEAT SENSITIVE _____
 PREGNANT _____
 FEVER IN THE LAST THREE MONTHS _____
 EAR PROBLEMS (OF ANY KIND) _____
 BLADDER / BOWEL CONTROL PROBLEMS _____
 CHLORINE OR CHEMICAL SENSITIVITY _____
 CURRENT ATHLETES FOOT / PLANTAR WART / FOOT DISEASE _____
 FEARFUL OF WATER OR POOL? _____

ARE YOU AWARE OF ANY CONDITION OR LIMITATIONS THAT MAY AFFECT YOUR EXERCISING IN A POOL? _____

CURRENT MEDICATIONS _____

PLEASE READ AND SIGN THE FOLLOWING:

TO MY KNOWLEDGE I HAVE NO MEDICAL OR PHYSICAL CONDITIONS OR LIMITATIONS THAT WOULD NOT PERMIT ME TO VOLUNTARILY PARTICIPATE IN THE ONGOINGT POOL PROGRAMS. I HAVE BEEN ADVISED OF THE RULES AND REGULATIONS AND I MUST ADHERE TO THESE AT ALL TIMES WHEN PARTICIPATING IN THE WATER WORKS PROGRAM. I UNDERSTAND THAT MY PARTICIPATION IS VOLUNTARY AND THAT WATER WORKS WILL NOT BE HELD RESPONSIBLE FOR ANY INJURIES THAT MIGHT BE SUSTAINED DURING THIS PROGRAM, EXCEPTING ACT OF NEGLIGENCE.

I CERTIFY THAT THE ABOVE INFORMATION GIVEN BY ME IS TRUE AND CORRECT. I AUTHORIZE WATER WORKS TOTAL REHAB TO RELEASE INFORMATION CONCERNING MY MEDICAL CONDITION AND / OR PROGRESS IN THERAPY TO MY INSURANCE COMPANY, ATTORNEY'S OFFICE AND / OR PHYSICIAN REFERRING ME. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ALL OUTSTANDING BALANCES.

PATIENTS SIGNATURE OR AUTHORIZED REPRESENTATIVE

DATE

WITNESS SIGNATURE

DATE

**WATER WORKS TOTAL REHAB
999 TRAIL TERRACE DRIVE
NAPLES, FLORIDA 34103
239-649-2222 FAX 239-649-0522**

NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At Water Works Total Rehab we are committed to treating and using protected health information responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 01, 2003, and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORDS / INFORMATION

Each time you visit Water Works Total Rehab a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to; ensure its accuracy, better understand who, what, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Water Works Total Rehab, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164,524,
- Amend your health record as provided in 45 CFR 164,528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164,528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164,552, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES

Water Works Total Rehab is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a request restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice.

We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions or would like additional information, you may contact the Physical Therapy Director, who also serves as this facility's Privacy Officer. The Physical Therapy Director can be contacted Monday through Friday, during regular business hours at 239-649-2222.

If you believe your privacy rights have been violated, you can file a complaint with this facility's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

We will use your health information for treatment.

For example: Information obtained by a Physical Therapist, Massage Therapist, Physical Therapist Assistant, or other member of your health care team, will be recorded in your record. The information will be used to determine the course of treatment that should work best for you. Your Physical Therapist will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the Physical Therapist, as well as your physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedure, treatment, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or member of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others lit it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Business associates: There are some services provided in our organization through contracts with business associates. Examples include the medical transcriber and the staff Psychologist. When these are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or any other person responsible for your care.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Financial Policy

Thank you for choosing Water Works Total Rehab. We provide our patients with high quality one-on-one care. We want to make sure you are aware of our guidelines. This will also allow you the opportunity to ask questions prior to treatment.

Cancellations and No Shows _____ Initials

Cancellations and No Shows compromise the timely care that our patients require. Broken appointments make it difficult to reschedule you within your allowed plan of care time frame. In addition it prevents other patients who are waiting to get an appointment to plan with such short notice. **In the event that you need to reschedule your appointment, we require 24 hours notice. If 24 hours notice is not given you may be assessed a \$25.00 fee, due and collected at your next appointment.**

Insurance and / or Medicare Guidelines _____ Initials

Verification and billing of your insurance is a courtesy we offer to our patients. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Obtaining verification of your insurance benefits is not a guarantee of payment. **You are ultimately responsible for any balance on your account.** Water Works accepts Medicare assignment, which pays 80% of your covered charges. We will bill your secondary or supplemental insurance for services rendered. If secondary or supplemental insurance does not cover any or part of you 20% co insurance, we will bill you for any outstanding balance.

Past Due Balances _____ Initials

We make every effort to work with our patients when there is a balance remaining after your insurance company has paid. However, past due balances will be handled thusly: **Accounts 90 days past due will be assessed 1½ % interest per month, and will be assigned to a collection agency.** In the event, you will be responsible for all interest, collection and legal fees, which may exceed the outstanding balance by up to 50%.

Returned Checks _____ Initials

For checks returned to us as unpaid by your bank, **you will be assessed a \$25.00 fee.**

I have read the Financial Policy. I understand and agree to the guidelines outlined above.

Patient's Signature or Authorized Representative

Date

Print Name: _____

Water Works Total Rehab • 999 Trail Terrace Drive • Naples • Florida • 34103

ACKNOWLEDGEMENT OF RECEIPT REGARDING PRIVACY NOTICE

I have been presented with a copy of the **NOTICE OF HEALTH INFORMATION PRACTICES**, detailing how my information may be used and disclosed as permitted by Federal and State law. I understand the contents and terms set forth by Water Works Total Rehab in accordance with HIPAA guidelines. I request the following restriction(s) concerning the use of my personal medical information:

I permit a copy of this authorization to be used in place of the original for submission to medical insurance / benefit companies. Furthermore, I request benefits be payable to Water Works Total Rehab by such medical insurance agencies abiding by applicable regulations.

Patient Signature: _____ Date: ___/___/___.

If not signed by the patient, please indicate relationship to patient (i.e. spouse, guardian, etc.)
Relationship: _____

If patient refuses to sign this document, please indicate your attempt to obtain a signature below.

Employee Signature: _____ Time: _____ Date: ___/___/___.

Reason for noncompliance: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize any agent / employee of Water Works Total Rehab to release any medical record information that may assist in the payment of my account, or as required by law, or to other medical parties that I so name. Related information could include, but is not limited to, diagnosis, treatment, or referral.

PHOTOGRAPHY AND AUTHORIZATION RELEASE

I hereby give my consent to Water Works Total Rehab and staff members to photograph myself for medical record purposes. I understand that Water Works Total Rehab shall be the owner of all such photographs. The agency will not use items for activities beyond those listed above without further written authorization.

DISPLAYING OF SCHEDULING

I hereby give my consent to Water Works Total Rehab to display my name on the scheduling board, which is displayed on the pool deck. I understand that other patients who are also being treated on the same day may see my name. I also understand that my name may be seen on the "Sign In" sheet by other patients who are being treated on that day.

CONSENT FOR TREATMENT

I personally, or through my physician, request outpatient rehabilitation services by Water Works Total Rehab which may include Physical Therapy. I do hereby consent to such treatment by Water Works Total Rehab as is reasonably prescribed by my physician or as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability of such treatment except in acts of negligence.

Patient Signature: _____ Date ___/___/___.
(Signature of Patient or authorized representative and relationship)

Witnessed By: _____ Date ___/___/___