

PATIENT RIGHTS ACKNOWLEDGMENT FORM

Form Disclaimer

This form has been developed by cataractlens.ca as a free public educational resource to support patient understanding and informed decision-making.

It is intended to reflect general professional standards and practices in Ontario and to help patients better understand their rights, options, and the cataract surgery process.

This form is provided for informational purposes only and may not reflect the specific policies or procedures of your clinic, surgeon, or healthcare provider. Patients are encouraged to review all information carefully and discuss any questions with their eye care professional before making decisions.

Use of this form is voluntary and at the discretion of the patient and provider. Cataractlens.ca assumes no responsibility for its use in clinical or non-clinical settings.

Patient Name: _____

Date of Birth: _____

Health Card Number (optional): _____

Clinic / Surgical Centre: _____

Surgeon: _____

Date: _____

Purpose

This form confirms that you have received, reviewed, and understood information regarding your rights as a patient undergoing cataract surgery in Ontario.

Your Rights as a Patient

Please read and initial each statement below:

- ☐ I understand that if my cataract surgery is medically necessary, it is fully covered by OHIP.
- ☐ I understand that I have the right to receive cataract surgery without paying for any optional services or features.
- ☐ I understand that optional services (sometimes referred to as enhanced or additional features) may be offered to me, but they are not required to proceed with surgery.
- ☐ I understand that choosing optional services will not affect my access to medically necessary cataract surgery.
- ☐ I understand that I have the right to ask questions and receive clear explanations about my treatment options before making any decisions.

☐ I understand that I may take time to consider my options and am not required to make a decision immediately.

☐ I understand that I can decline any optional services and still receive standard, fully insured care.

☐ I understand that I should be informed of any costs associated with optional services before agreeing to them.

☐ I understand that I may seek a second opinion if I am unsure about my treatment options.

☐ I understand that my care should not be influenced by whether or not I choose optional services.

Acknowledgment

By signing below, I confirm that:

- I have received information regarding my rights as a patient undergoing cataract surgery.
- I have had the opportunity to ask questions.
- My questions have been answered to my satisfaction.
- I understand the difference between medically necessary services covered by OHIP and optional services that are not covered.

Patient Signature: _____

Date: _____

Witness / Staff Name: _____

Signature: _____

Date: _____

Notes (if applicable)