This is the printout we hand out in the office for the patient portal setup.

Print Instructions | Cancel

If you were sent an email with a link go to page 4

Hello Evisit Example,

You have been invited to safely and securely view your medical records online using https://www.yourhealthfile.com/portal/login.jsp

Logging in today allows you to see all of your current and past medical records, your prescription history, and so much more.

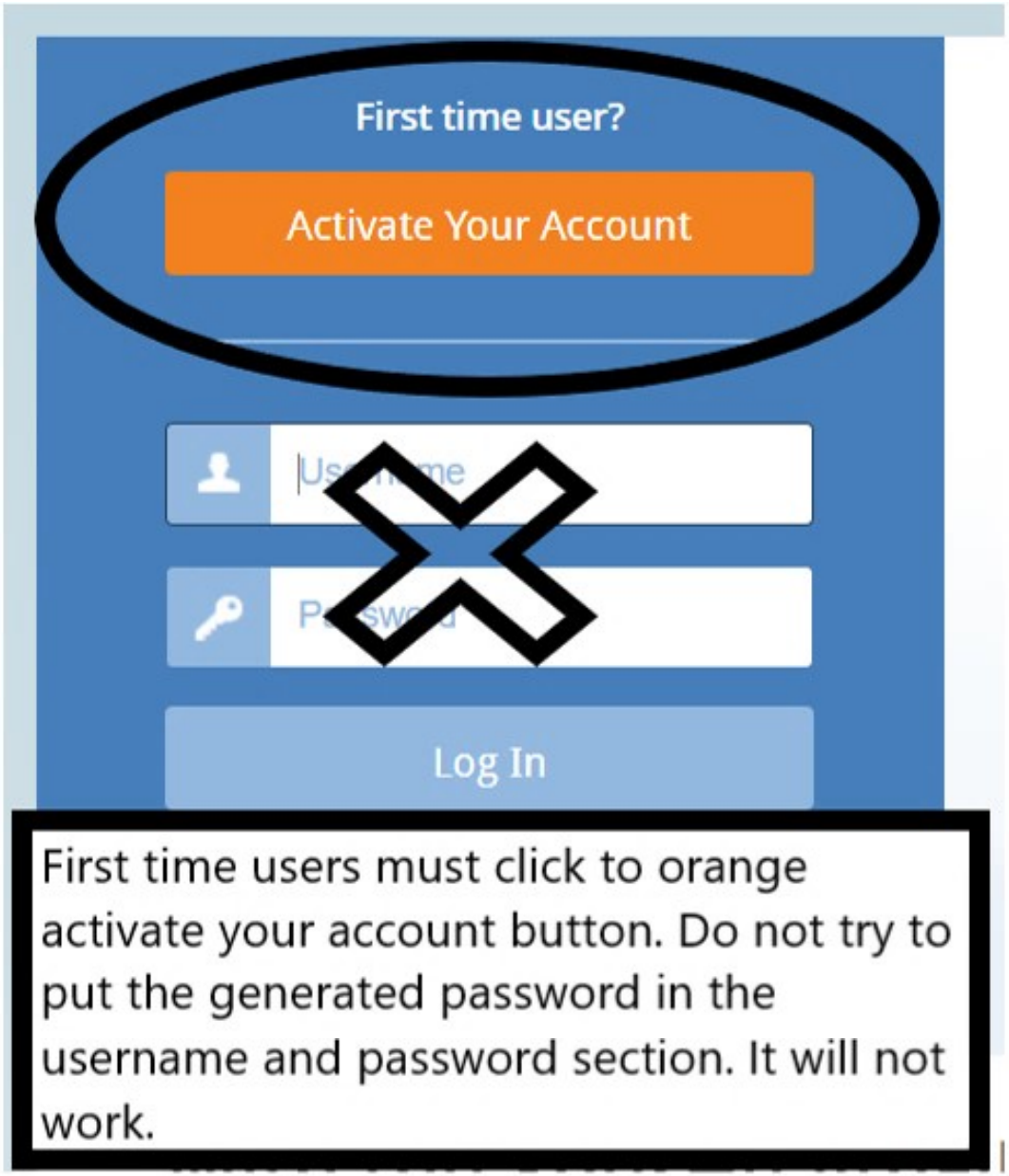
To sign up, please follow these instructions:

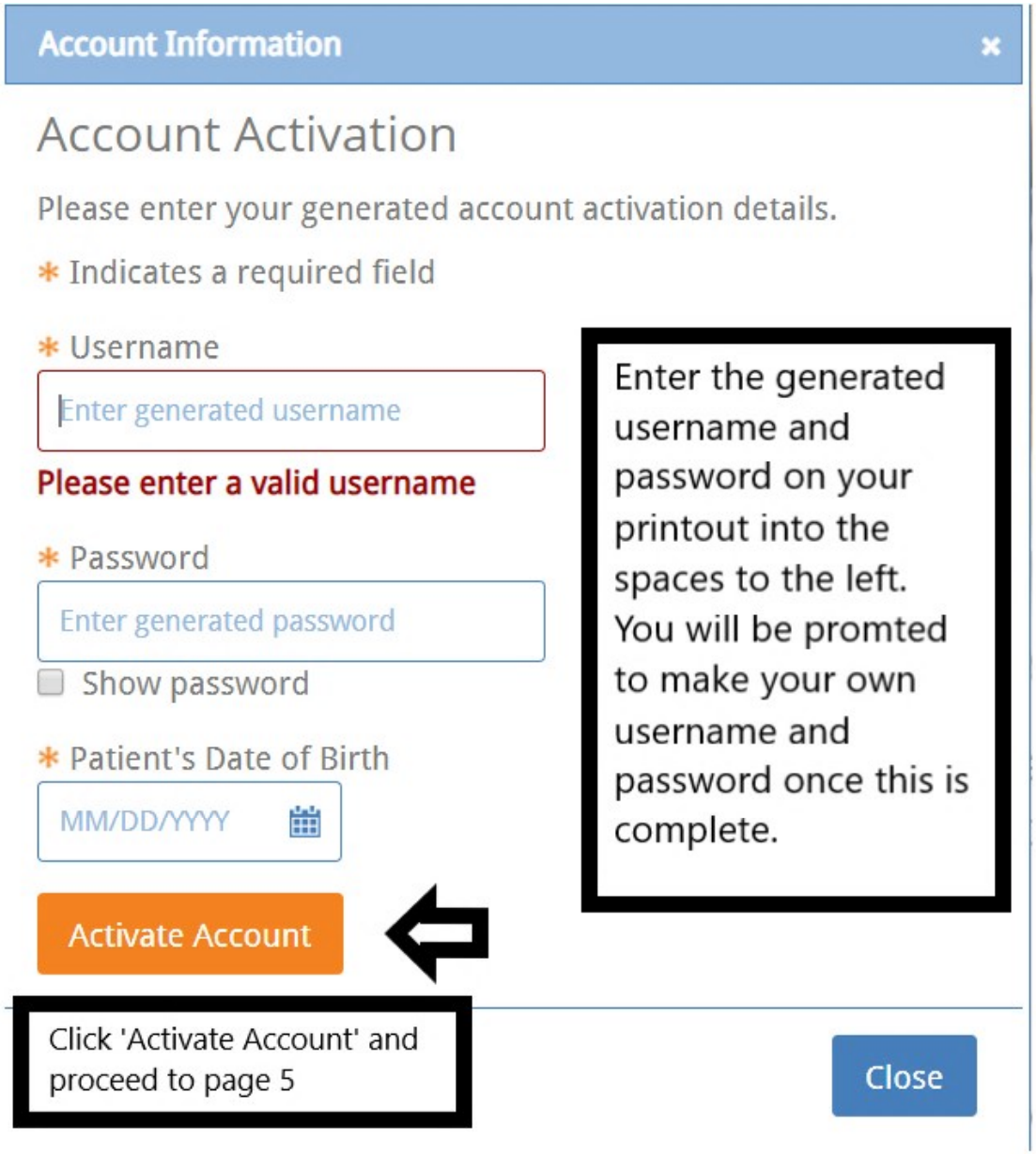
1. Visit : https://www.yourhealthfile.com/portal/login.jsp from any web-enabled device.
2. Click the "Activate your account here" button above the User Login form. An Account Activation screen will display.
3. In the "Username" field, enter: eexam286362590
4. In the "Password" field, enter: u5so2jo1
5. In the "Patient's Date of Birth, enter the patient's date of birth.
6. Click the "Activate Account" button. Upon confirmation, the Update Account screen will display and you will be prompted to enter your desired account details.
7. Complete the Update Account form, then click the "Update Account" button.

Welcome to YourHealthFile. If prompted, please follow the on-screen Patient Registration instructions to set up your new YourHealthFile Patient Portal account.

For any questions or concerns, please do not hesitate to contact your medical provider's office.

Thank you,
https://www.yourhealthfile.com/portal/login.jsp


First time user?
Activate Your Account
Log In
First time users must click to orange activate your account button. Do not try to put the generated password in the username and password section. It will not work.


Account Information
Account Activation
Please enter your generated account activation details.
* Indicates a required field
* Username
Enter generated username
Please enter a valid username
* Password
Enter generated password
Show password
* Patient's Date of Birth
MM/DD/YYYY
Activate Account
Enter the generated username and password on your printout into the spaces to the left. You will be promted to make your own username and password once this is complete.
Click 'Activate Account' and proceed to page 5
Close

Aban Care Clinic LLC

If you were sent an email to activate your patient portal. Please check your email. The email will look like this. Click on 'Click here to begin the registration process to get started.

Hello EVISIT EXAMPLE,

You are receiving this email because you have been granted access to the following YourHealthFile Patient Portal accounts:

EXAMPLE, EVISIT

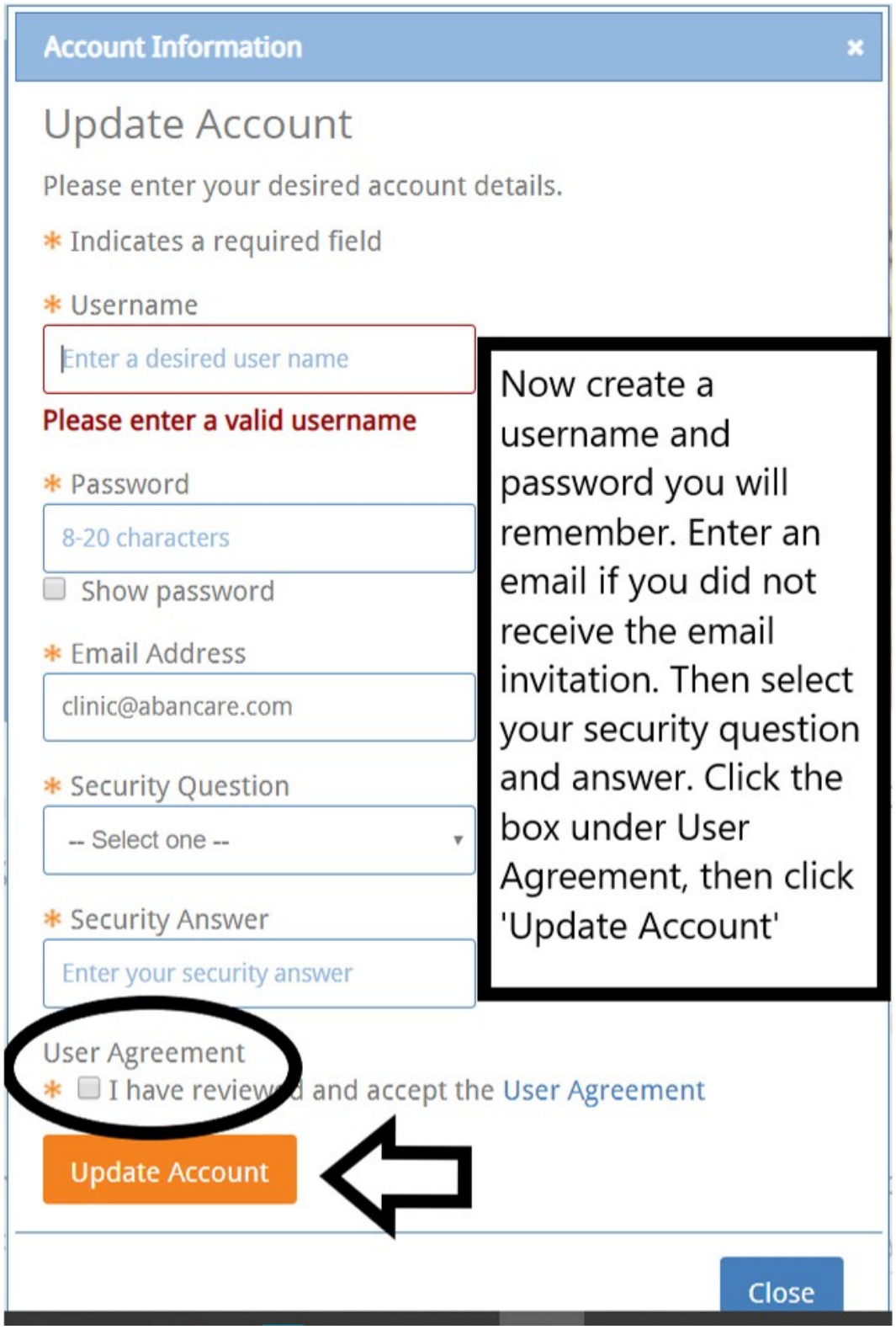
Please click the link below to register using the YourHealthFile Patient Portal.

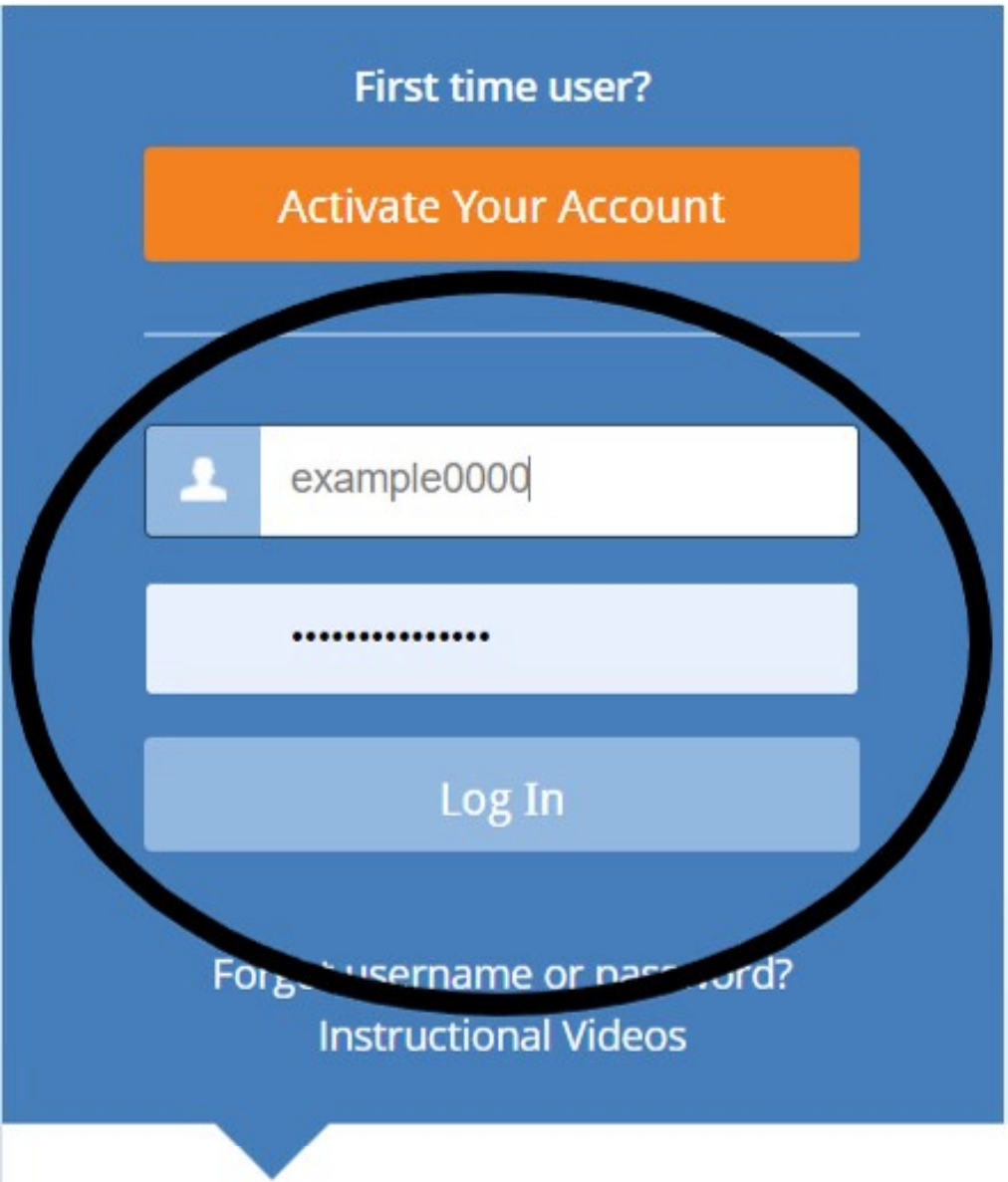
Click here to begin the registration process.

What is YourHealthFile?

YourHealthFile is a personal health record (sometimes referred to as PHR). Your provider has upgraded to an electronic health record to modernize the practice of medicine and, more importantly, to increase the quality of health care. YourHealthFile is your view into the electronic health record and provides access to your account information, medical records, and appointments.

https://www.yourhealthfile.com/portal/login.jsp


Account Information
Update Account
Please enter your desired account details.
* Indicates a required field
* Username
Enter a desired user name
Please enter a valid username
* Password
8-20 characters
Show password
* Email Address
clinic@abancare.com
* Security Question
-- Select one --
* Security Answer
Enter your security answer
User Agreement
* I have reviewed and accept the User Agreement
Update Account
Close
Now create a username and password you will remember. Enter an email if you did not receive the email invitation. Then select your security question and answer. Click the box under User Agreement, then click 'Update Account'



YourHealthFile®

Your Portal to a Healthy Life

Your new user name and password should populate into the required fields. If not enter them there now.

Then click 'Log In'

Now you will start the registration process. Make sure your information is correct in all required fields as you go through this process.

Click 'Next' to start

PRINT PAGE LOG OUT

Patient Registration

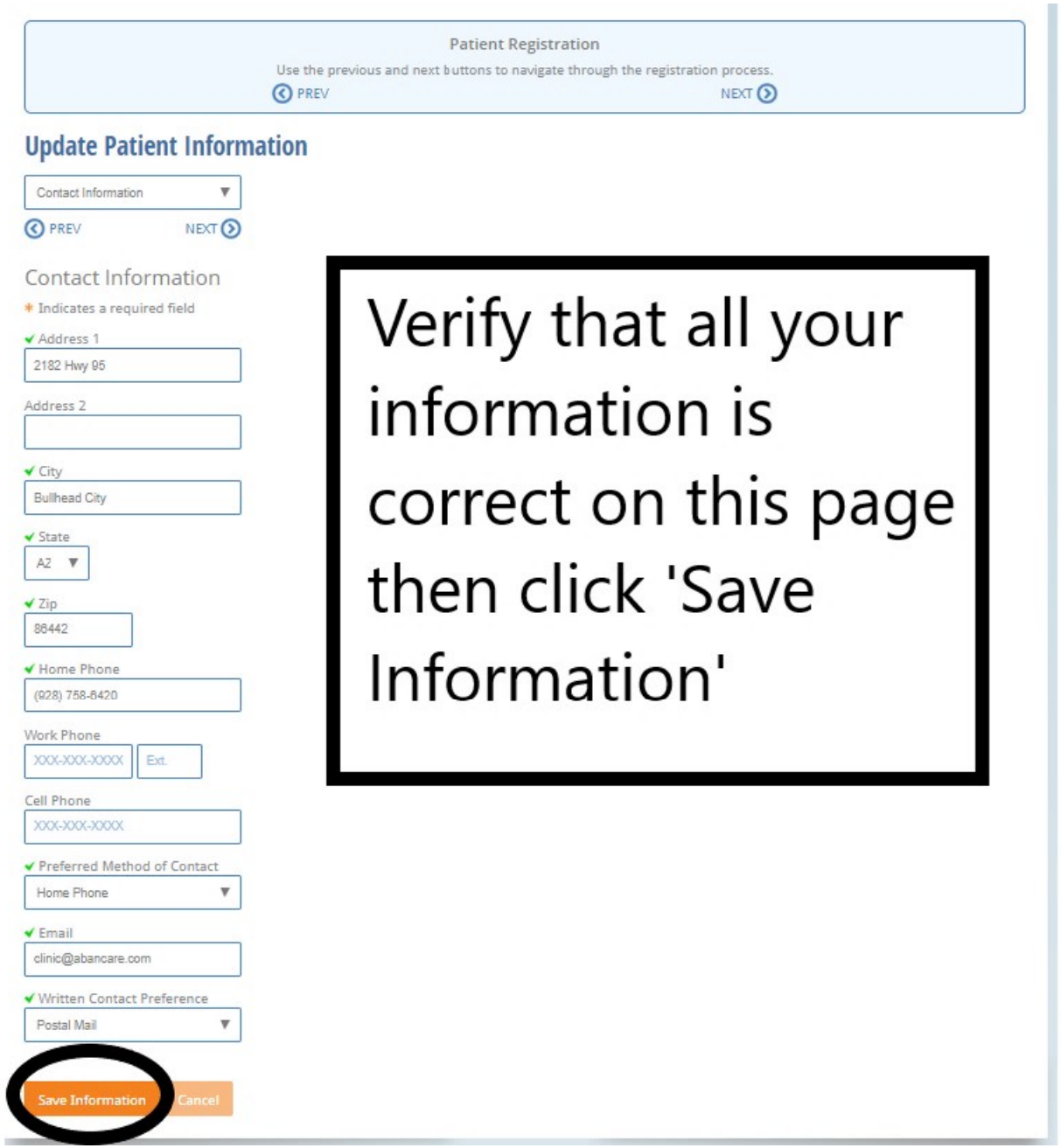
Use the previous and next buttons to navigate through the registration process.

NEXT

Patient Registration

Welcome to YourHealthFile! You have been directed here because this is your first time logging in and we need information from you, or your practice has added a document for you to review.


Patient Registration
Use the previous and next buttons to navigate through the registration process.
PREV
NEXT
Update Patient Information
Patient Information
NEXT
Patient Information
* Indicates a required field
First Name
EVISIT
Middle Initial
Last Name
EXAMPLE
Date of Birth
01/01/1900
Sex
Female
Male
Race
Unknown
ADD ADDITIONAL RACE
Ethnicity
Unknown
ADD ADDITIONAL ETHNICITY
Language
English
Country
United States of America
SSN
Show SSN
Save Information
Cancel
Fill out all the fields on this page and then click 'Save Information'


Patient Registration
Use the previous and next buttons to navigate through the registration process.
PREV
NEXT
Update Patient Information
Contact Information
PREV
NEXT
Contact Information
* Indicates a required field
Address 1
2182 Hwy 95
Address 2
City
Bullhead City
State
AZ
Zip
86442
Home Phone
(928) 758-6420
Work Phone
XXX-XXX-XXXX
Ext.
Cell Phone
XXX-XXX-XXXX
Preferred Method of Contact
Home Phone
Email
clinic@abancare.com
Written Contact Preference
Postal Mail
Save Information
Cancel
Verify that all your information is correct on this page then click 'Save Information'

Patient Registration

Use the previous and next buttons to navigate through the registration process.

PREV NEXT

Update Patient Information

Emergency Contact

PREV NEXT

Emergency Contact

* Indicates a required field

✔ Emergency First Name

Erika

✔ Emergency Last Name

Major

✔ Emergency Phone

✔ Relationship to Patient

Foster Daughter

Emergency Address 1

Emergency Address 2

Emergency City

Emergency State

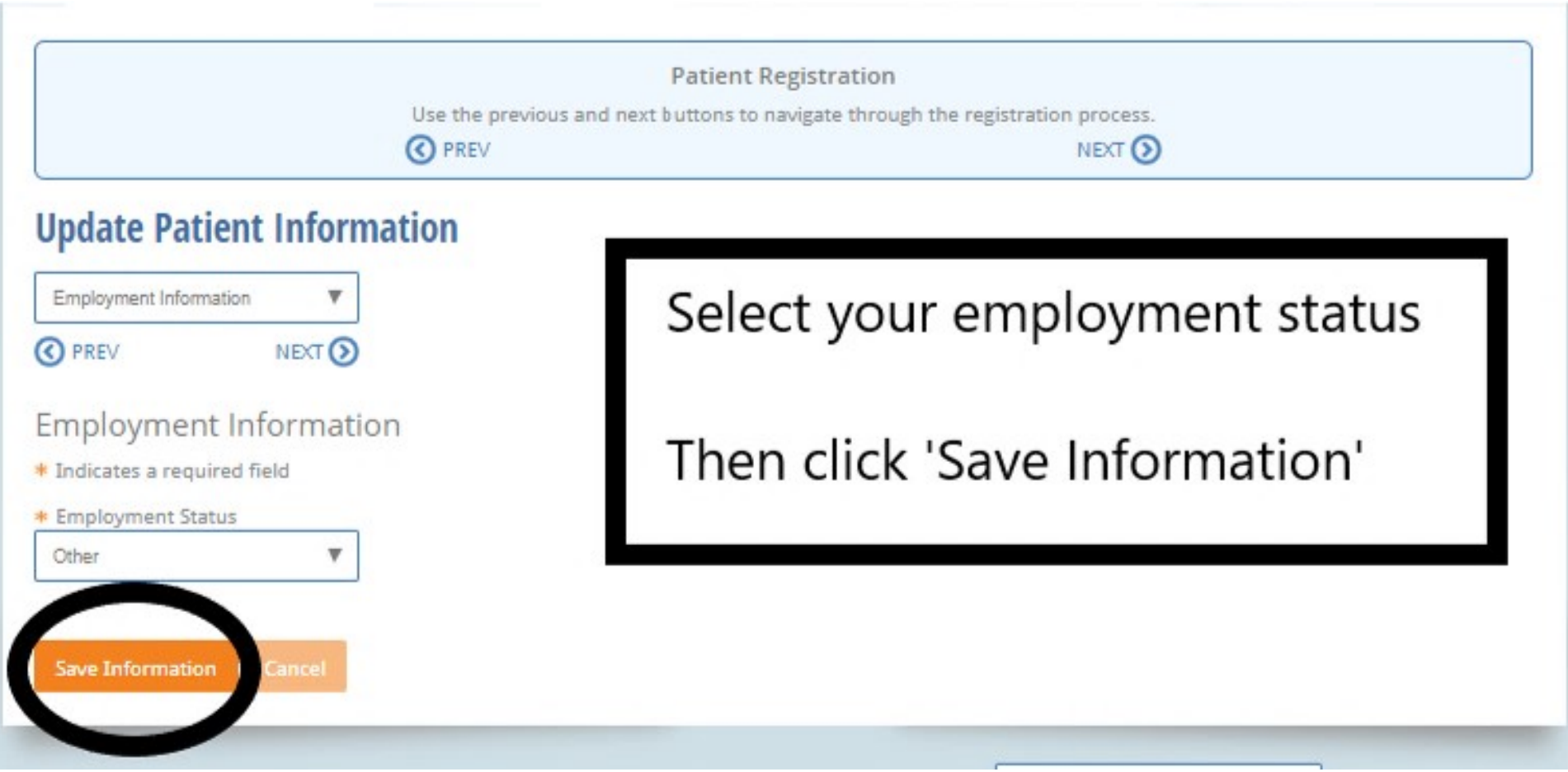
Emergency Zip

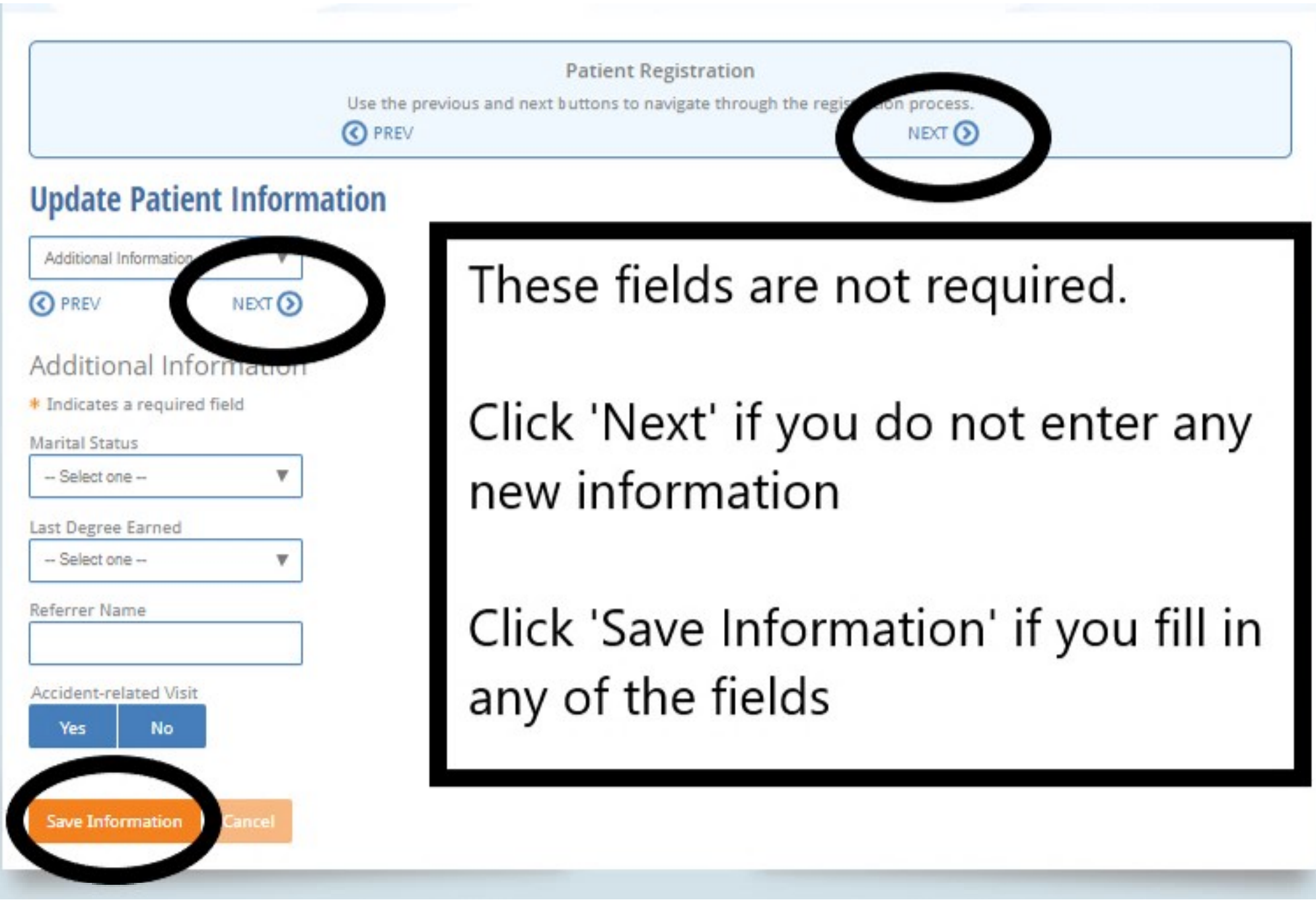
XXXXX

Save Information Cancel

Fill out your emergency contact's first and last name, phone number and their relation to you.

Then click 'Save Information'


Patient Registration
Use the previous and next buttons to navigate through the registration process.
PREV
NEXT
Update Patient Information
Employment Information
PREV
NEXT
Employment Information
* Indicates a required field
* Employment Status
Other
Save Information
Cancel
Select your employment status
Then click 'Save Information'


Patient Registration
Use the previous and next buttons to navigate through the registration process.
PREV
NEXT
Update Patient Information
Additional Information
PREV
NEXT
Additional Information
* Indicates a required field
Marital Status
-- Select one --
Last Degree Earned
-- Select one --
Referrer Name
Accident-related Visit
Yes
No
Save Information
Cancel
These fields are not required.
Click 'Next' if you do not enter any new information
Click 'Save Information' if you fill in any of the fields

PRINT PAGE LOG OUT

Patient Registration

Use the previous and next buttons to navigate through the regist on process.

PREV NEXT

Update Patient Information

Primary Care Physicia

PREV NEXT

Primary Care Phy

Physician Name

Practice Name

Address

City

State

--

Zip

XXXXX

Save Information ancel

These fields are not required.

Click 'Next' if you do not enter any new information

Click 'Save Information' if you fill in any of the fields

PRINT PAGE LOG OUT

Patient Registration

Use the previous and next buttons to navigate through the registration process.

PREV NEXT

Update Patient Information

Preferred Pharmacy

PREV NEXT

Preferred Pharmacy

Pharmacy Name

Pharmacy Phone

XXX-XXX-XXXX

Address

City

State

--

Zip

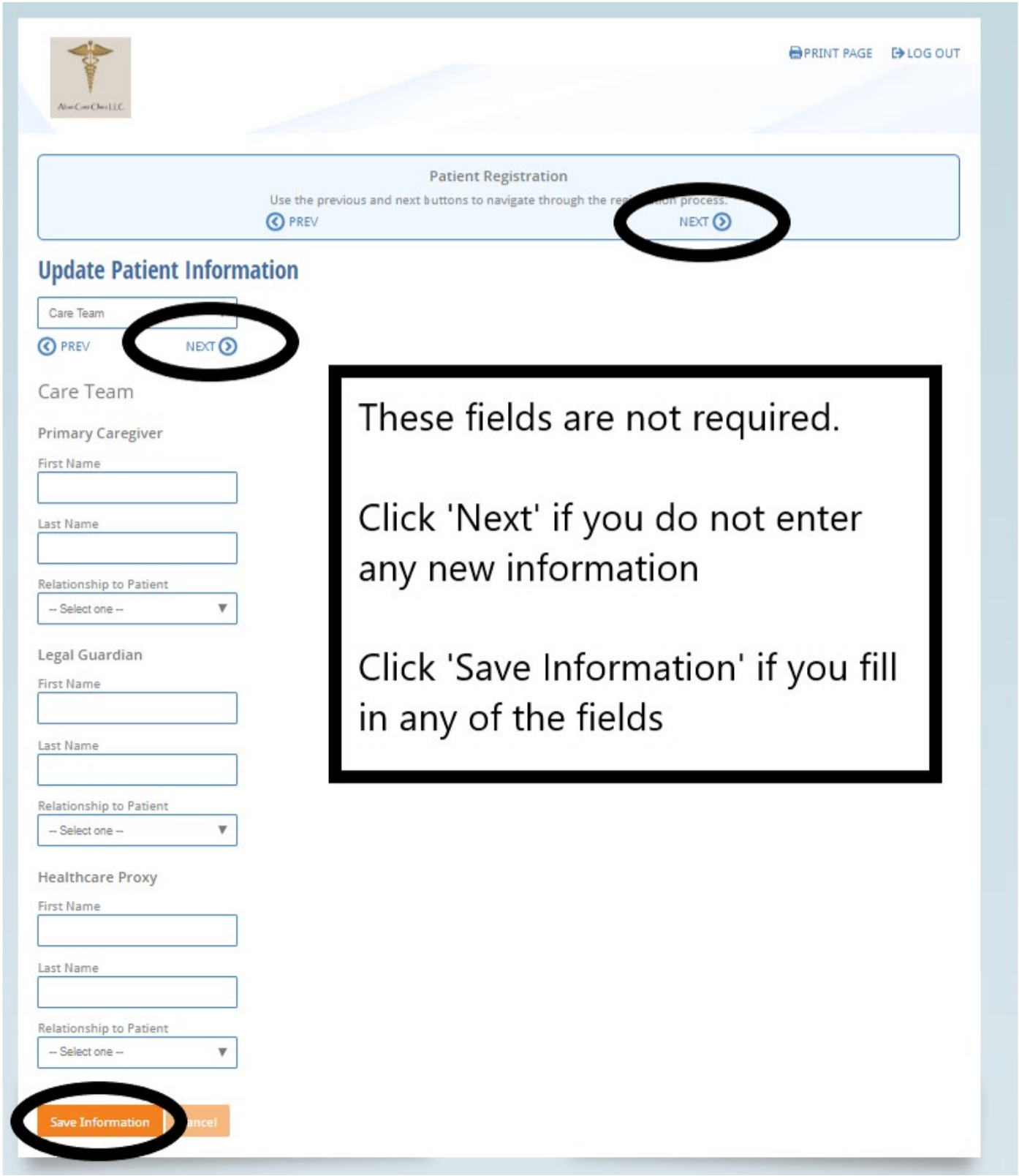
XXXXX

Save Information Cancel

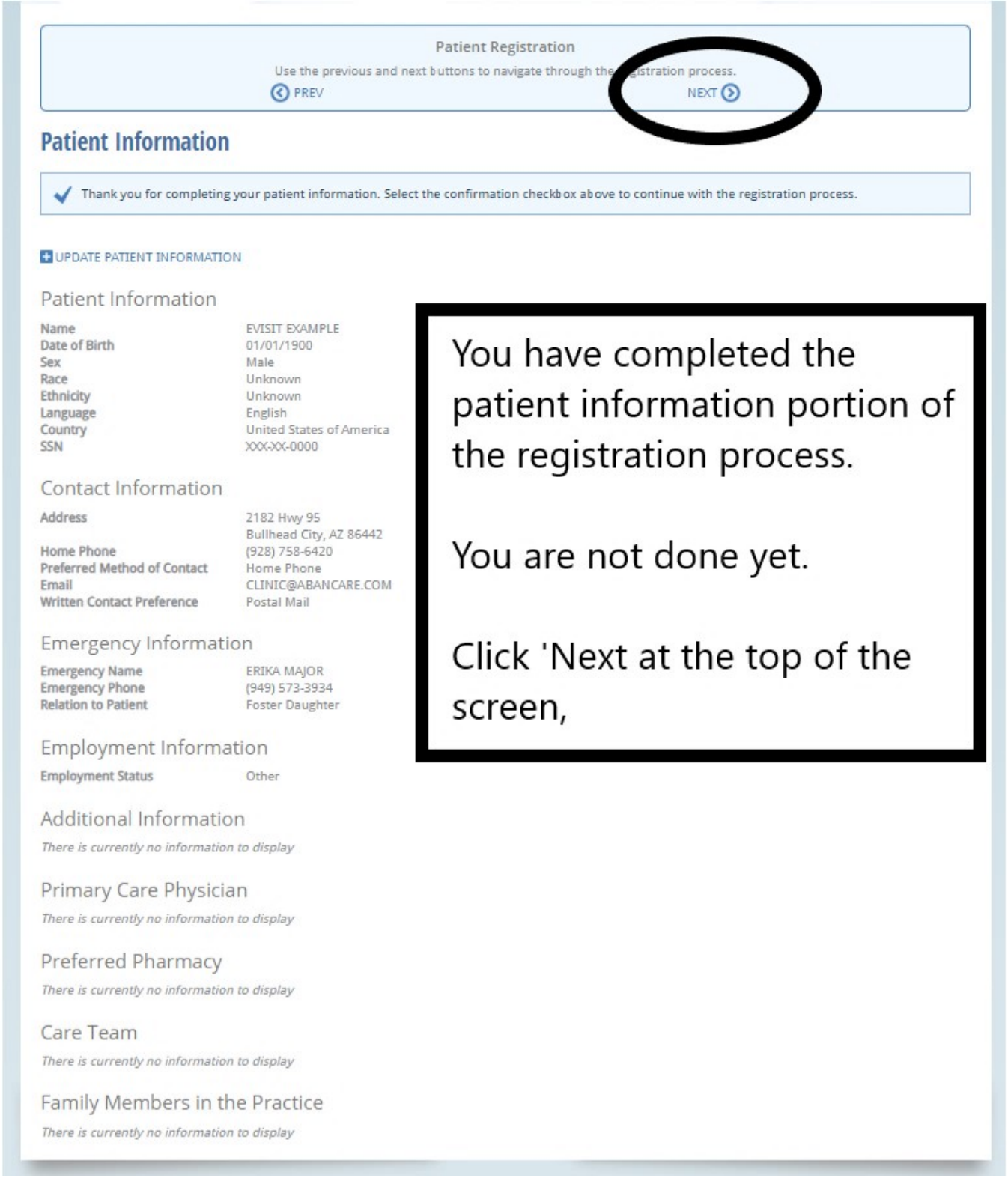
These fields are not required.

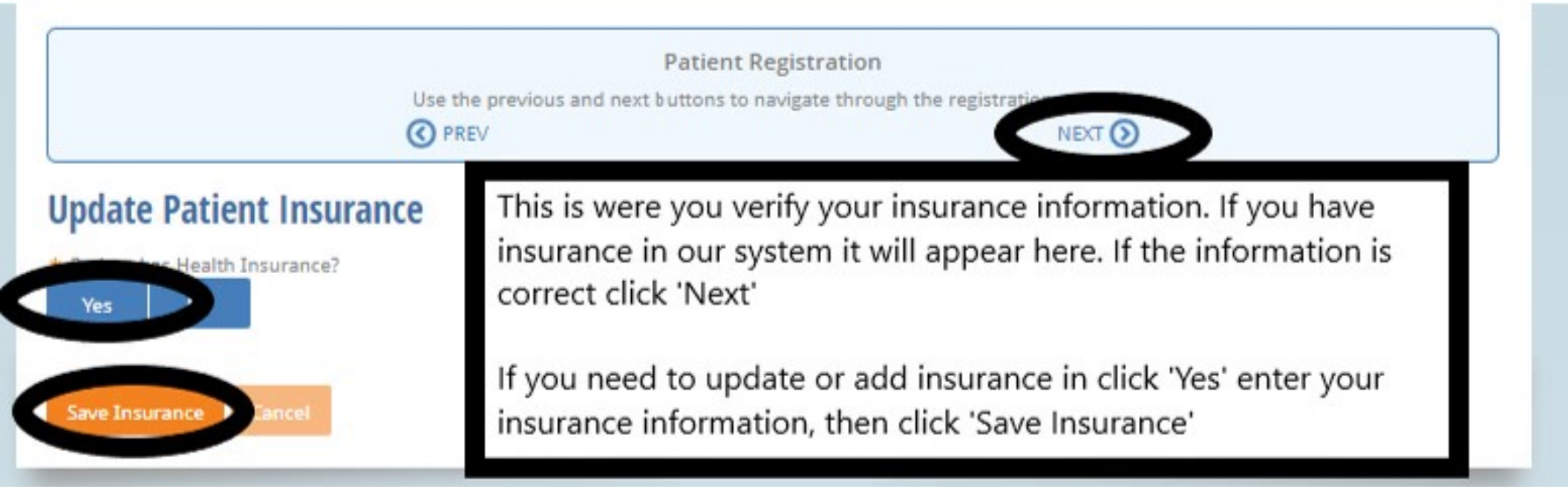
Click 'Next' if you do not enter any new information

Click 'Save Information' if you fill in any of the fields


PRINT PAGE
LOG OUT
Patient Registration
Use the previous and next buttons to navigate through the registration process.
PREV
NEXT
Update Patient Information
Care Team
PREV
NEXT
Care Team
Primary Caregiver
First Name
Last Name
Relationship to Patient
-- Select one --
Legal Guardian
First Name
Last Name
Relationship to Patient
-- Select one --
Healthcare Proxy
First Name
Last Name
Relationship to Patient
-- Select one --
Save Information
These fields are not required.
Click 'Next' if you do not enter any new information
Click 'Save Information' if you fill in any of the fields


PRINT PAGE
LOG OUT
Patient Registration
Use the previous and next buttons to navigate through the registration process.
PREV
NEXT
Update Patient Information
Family Members in the Practice
PREV
Family Members in the Practice
Name
Relationship to Patient
-- Select one --
Name
Relationship to Patient
-- Select one --
Name
Relationship to Patient
-- Select one --
Name
Relationship to Patient
-- Select one --
Save Information
These fields are not required.
Click 'Next' if you do not enter any new information
Click 'Save Information' if you fill in any of the fields


Patient Registration
Use the previous and next buttons to navigate through the registration process.
PREV
NEXT
Patient Information
Thank you for completing your patient information. Select the confirmation checkbox above to continue with the registration process.
UPDATE PATIENT INFORMATION
Patient Information
Name EVISIT EXAMPLE
Date of Birth 01/01/1900
Sex Male
Race Unknown
Ethnicity Unknown
Language English
Country United States of America
SSN XXX-XX-0000
Contact Information
Address 2182 Hwy 95
Bullhead City, AZ 86442
Home Phone (928) 758-6420
Preferred Method of Contact Home Phone
Email CLINIC@ABANCARE.COM
Written Contact Preference Postal Mail
Emergency Information
Emergency Name ERIKA MAJOR
Emergency Phone (949) 573-3934
Relation to Patient Foster Daughter
Employment Information
Employment Status Other
Additional Information
There is currently no information to display
Primary Care Physician
There is currently no information to display
Preferred Pharmacy
There is currently no information to display
Care Team
There is currently no information to display
Family Members in the Practice
There is currently no information to display
You have completed the patient information portion of the registration process.
You are not done yet.
Click 'Next at the top of the screen,


Patient Registration
Use the previous and next buttons to navigate through the registrati
PREV
NEXT
Update Patient Insurance
Health Insurance?
Yes
Save Insurance
ancel
This is were you verify your insurance information. If you have insurance in our system it will appear here. If the information is correct click 'Next'
If you need to update or add insurance in click 'Yes' enter your insurance information, then click 'Save Insurance'

Patient Registration

Use the previous and next buttons to navigate through the registration process.

PREV NEXT

Release of Information

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential releases and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry our treatment, payment or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to releasing information to me in the following manners.

Via Mail

- ☐ Ok to Mail to Home Address
- ☐ Ok to Mail to Work Address

Via Home Telephone

- ☐ Ok to leave detailed message
- ☐ Leave call back number only

Via Work Telephone

- ☐ Ok to leave detailed Message
- ☐ Leave call back number only

Via Fax

- ☐ Ok to Fax to

Please consent to how you would like information released to you. A fax number is not required, but please select one option for mail and one option for Home Telephone.

Save Information

Then click 'Save Information'

In this next part, read each document and click 'Next'

PRINT PAGE LOG OUT

Patient Registration

Use the previous and next buttons to navigate through the regist

PREV NEXT

Patient Registration Document

Page: 1 of 1 Automatic Zoom

Aban Care Clinic LLC

2182 Highway 95
Bullhead City, AZ 86442
Phone: 928-758-6420
Fax: 877-712-4076

Patient Conduct Agreement

This is a behavioral agreement between me and Aban Care Clinic. I understand that I am welcome to

PRINT PAGE LOG OUT

Read the document and click 'Next'

Patient Registration

Use the previous and next buttons to navigate through the registrati

PREV NEXT

Patient Registration Document

Page: 1 of 1 Automatic Zoom

Aban Care Clinic LLC

2182 Highway 95
Bullhead City, AZ 86442
Phone: 928-758-6420
Fax: 877-712-4076

Financial Responsibility Agreement

We at Aban Care Clinic are committed to providing quality care and service to all of our patients. Your understanding of our financial policies is important to our professional relationship. Please take a moment to read through this document to fully understand your responsibility as a patient and sign and date the bottom.

Insurance Information: You are responsible for making sure we have all up-to-date insurance information on file, including current insurance cards. Failure to provide this information in a timely manner may result in the charges being billed to you. We ask that you

Read the document and click 'Next'

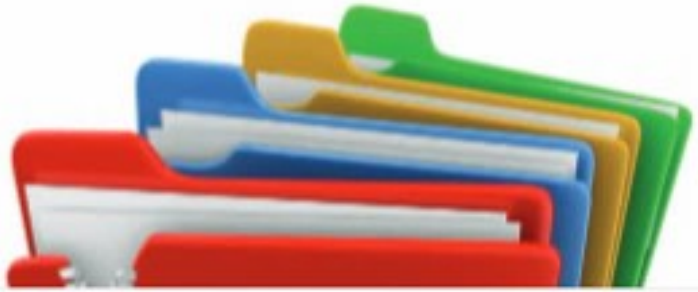
PREV NEXT

Patient Registration Document

Page: 1 of 5 Automatic Zoom

Aban Care Clinic LLC

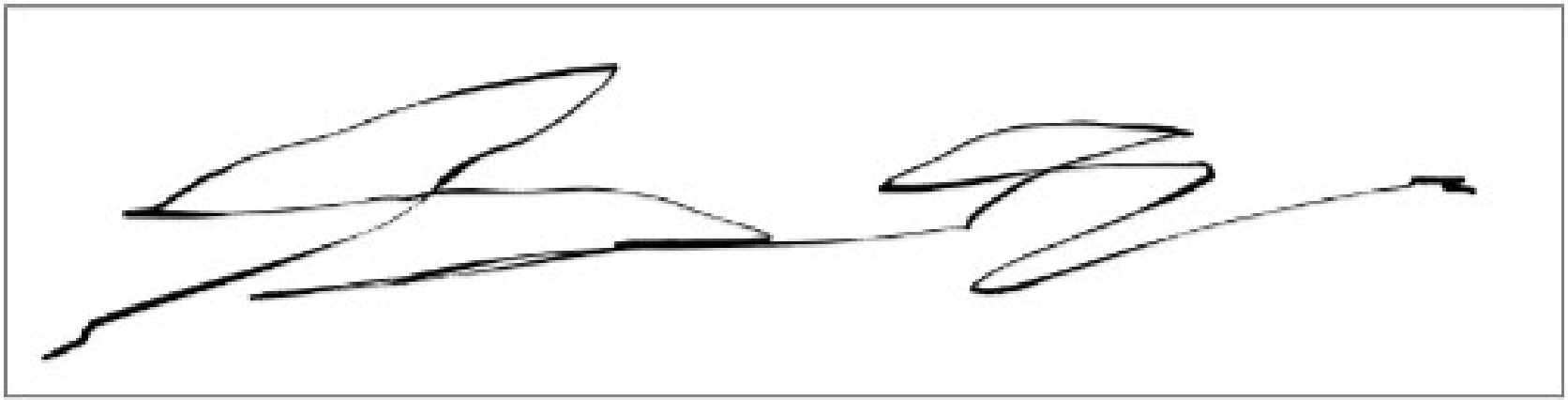
2182 Hwy 95
Bullhead City, AZ 86442
www.abancare.com
928-758-6420



Your Information.
Your Rights.
Our Responsibilities.

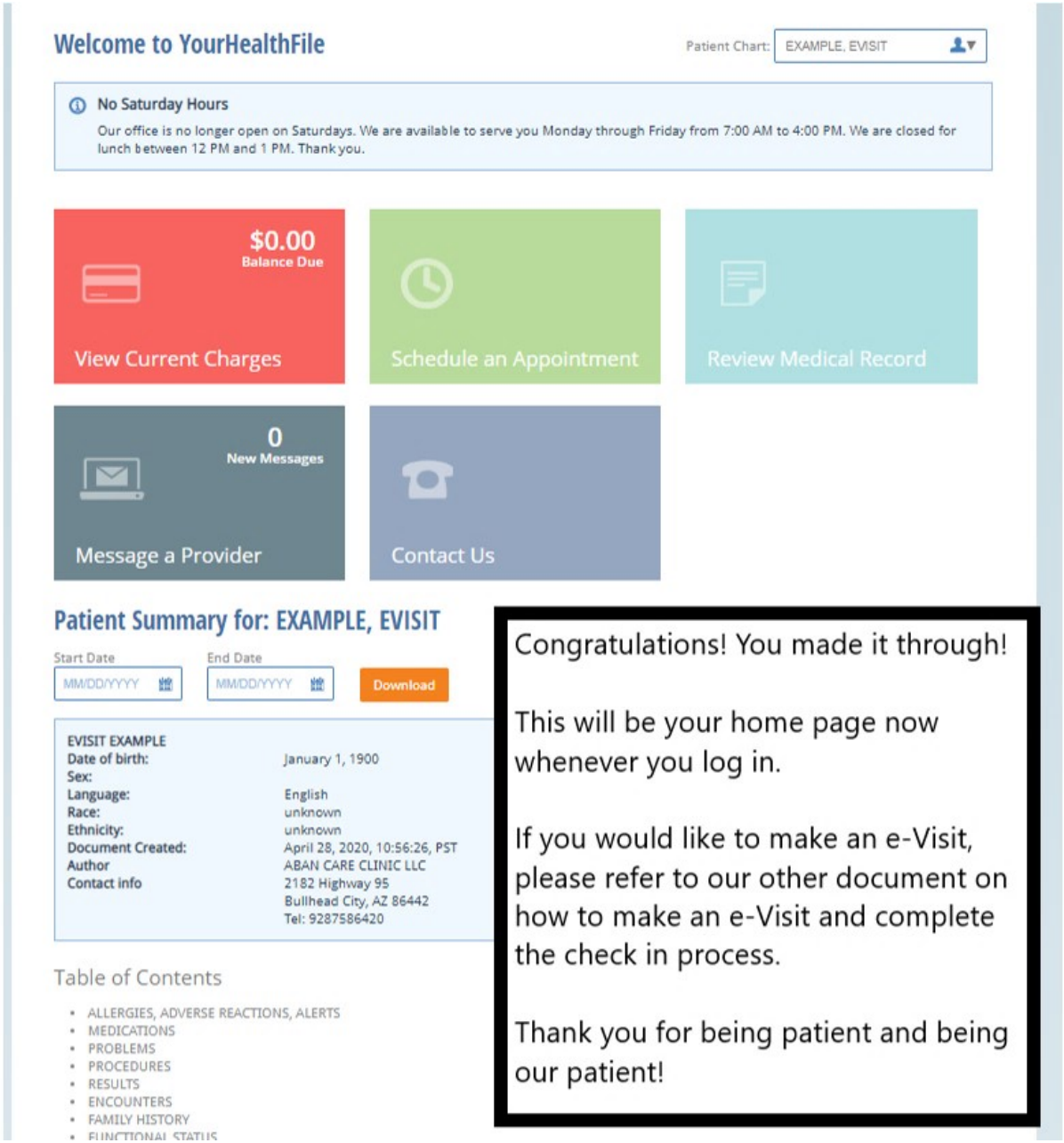
Now you will sign. It's okay my signature doesn't look perfect either.
Then click 'Sign and Complete Registration'

By signing below, I confirm that I have read and understand the documents and that any information I have supplied is true and accurate.



Sign and Complete Registration

Review


Welcome to YourHealthFile
Patient Chart: EXAMPLE, EVISIT
No Saturday Hours
Our office is no longer open on Saturdays. We are available to serve you Monday through Friday from 7:00 AM to 4:00 PM. We are closed for lunch between 12 PM and 1 PM. Thank you.
$0.00
Balance Due
View Current Charges
Schedule an Appointment
Review Medical Record
0
New Messages
Message a Provider
Contact Us
Patient Summary for: EXAMPLE, EVISIT
Start Date
End Date
MM/DD/YYYY
MM/DD/YYYY
Download
EVISIT EXAMPLE
Date of birth: January 1, 1900
Sex:
Language: English
Race: unknown
Ethnicity: unknown
Document Created: April 28, 2020, 10:56:26, PST
Author ABAN CARE CLINIC LLC
Contact info 2182 Highway 95
Bullhead City, AZ 86442
Tel: 9287586420
Table of Contents
ALLERGIES, ADVERSE REACTIONS, ALERTS
MEDICATIONS
PROBLEMS
PROCEDURES
RESULTS
ENCOUNTERS
FAMILY HISTORY
FUNCTIONAL STATUS
Congratulations! You made it through!
This will be your home page now whenever you log in.
If you would like to make an e-Visit, please refer to our other document on how to make an e-Visit and complete the check in process.
Thank you for being patient and being our patient!