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@SparkAndThriveTherapy

HIPAA NOTICE OF PRIVACY PRACTICES (NPP)

Effective Date: September 01, 2026

This Notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

This HIPAA Notice of Privacy Practices (NPP) is part of, and should be read together with, the Client-Therapist Service Agreement and Informed Consent for Treatment forms, which contain the governing law and entire-agreement terms for the full relationship between the parties.

Eri SLP PLLC D.B.A. Spark Thrive Therapy, SLP ("Company") is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and New York State privacy laws to maintain the privacy of your protected health information ("PHI"), provide this Notice of our legal duties and privacy practices, and notify you following a breach of unsecured PHI.

How We May Use and Disclose Your Information

The Company may use or disclose your PHI for the following purposes:

Treatment

To provide, coordinate, or manage your care. This includes communication with other healthcare providers with your consent.

Payment

To obtain payment for services. For private-pay-only clients, this is limited to billing you directly and potential Superbills. For clients whose services are being covered by the New York City Department of Education (NYC DOE), there is no financial responsibility for Services actually authorized and paid for by NYC DOE.

Healthcare Operations

For activities necessary to support our business operations, including quality assessment, compliance, or administrative duties.

Required by Law

We may disclose PHI when required by federal or New York State law, including:

- public health reporting
- child abuse or neglect reporting
- certain law enforcement requests
- court orders or subpoenas
- health oversight activities
- threats of harm to self or others
- mandated reporting for vulnerable populations

Other Uses and Disclosures Require Your Written Authorization

We will not disclose your PHI for marketing, fundraising, or disclosures that constitute a sale of PHI without your written consent. You may revoke any authorization at any time in writing.

Your Rights

You have the right to:

- inspect and obtain a copy of your record;
- request corrections to your record;
- request restrictions on certain uses or disclosures (we may not be required to agree);
- request confidential communications;
- receive an accounting of certain disclosures;
- receive a paper or electronic copy of this Notice;
- file a complaint without fear of retaliation.

Complaints may be filed with the Company or with the U.S. Department of Health and Human Services. To file a complaint with the Company, contact Eri Tina Siklas at info@sparkandthrivetherapy.com or 516-204-2388. To file a complaint with the U.S. Department of Health and Human Services, visit www.hhs.gov/ocr/privacy/hipaa/complaints or call 1-800-368-1019. Record Retention: Client health records will be retained for a minimum of seven (7) years from the date of last service, or, for records of a minor client, until the client reaches age 21 or seven (7) years from the date of last service, whichever is later, consistent with New York State recordkeeping requirements for licensed health professionals.

Company Duties

The Company is required to:

- maintain the privacy of PHI;
- provide you with this Notice;
- comply with the Notice currently in effect;
- notify you of any unauthorized breach of your unsecured PHI.

Confidentiality

The Company will maintain the confidentiality of all Client information in compliance with HIPAA and New York law. Information may be disclosed only as allowed by law or with written authorization.

Governing Law

This Agreement is governed by the laws of the State of New York, without regard to its conflict-of-law principles.

By signing below, you acknowledge that you have received a copy of this Notice of Privacy Practices. Your signature acknowledges receipt only and does not limit any rights or protections this Notice describes.

Acknowledgment and Consent

By signing below, you confirm the following:

- You have read and understand all policies stated above.
- You agree to abide by all terms of this Agreement.
- You acknowledge that this Agreement becomes effective upon signature by all required parties.

☐ I have read, understand, and agree to the above terms and conditions.

Print Client Name: _____ Date: _____

Print Caregiver Name: _____ Relationship to the client: _____

Caregiver Signature if client is under 18-years of age: _____

Client signature if over 18-years of age: _____