Heather Bedell, LCPC
Licensed Clinical Professional Counselor
(913) 213-3760

Stephanie Allegre, LSCSW
Licensed Specialist Clinical Social Worker
(785) 418-1670

Consent for Group Treatment

I, ____, give permission for my child,

____, (DOB:_____________________) to

participate in group treatment with Heather Bedell, LCPC, and Stephanie Allegre, LSCSW. I have legal custody or guardianship of this child and have the legal right to authorize the care, treatment and counsel of this child. I understand that the group leaders reserve the right to withdraw any participant at any time participation in the group is no longer appropriate. I release group facilitators from any liability taken by participants outside of group time. Both myself, and my child, are aware that in the event any information is shared suggesting that they, or others, are in danger, parents will be notified by the group facilitators. I understand that myself and/or my family members are not allowed to bring friends or family to the support group who have not first initiated services for themselves. This also helps to ensure confidentiality. There are no fees for this group participation.

____ _______________________
Parent/Guardian Signature Date

____
Parent/Guardian Phone Number