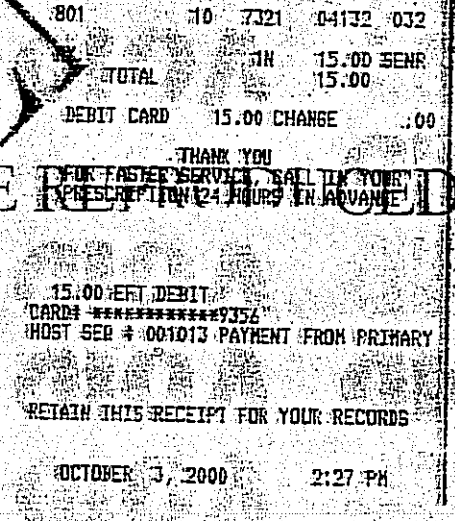
CONFIDENTIAL

DOCUMENT IS NOT TO BE RETURNED.



801 10 7321 04132 032

TOTAL 1N 15.00 SENR
15.00

DEBIT CARD 15.00 CHANGE .00

THANK YOU
FOR FASTER SERVICE, CALL IN YOUR
PRESCRIPTION 24 HOURS IN ADVANCE

15.00 EFT DEBIT
CARD# **********9356
HOST SEQ # 001013 PAYMENT FROM PRIMARY

RETAIN THIS RECEIPT FOR YOUR RECORDS

OCTOBER 3, 2000 2:27 PM

10-04-04 Order
0355

September 23, 2000

has changed the dosage and timing for my Wellbutrin. Please find enclosed a receipt for same. Consider this an invoice for same.

Also, I have spoken to my H.R. person who handles insurance problems. She stated I would probably get the $7.99 refunded. If that happens, I'll forward that same amount to you.

Total: $15.00

Thank you,

10-04-04 Order
0356

CATHOLIC DIOCESE OF FORT WORTH

PAYMENT ORDER / ACCOUNTS PAYABLE VOUCHER FORM

Accounting Use Only

VENDOR NO.: ENTERED BY/DATE:

DATE: October 26, 2000 TAX PAYER ID NO.:

PLEASE PAY TO:

PAYMENT RELATES TO:
X DIOCESE
FOUNDATION

INVOICES TO BE PAID

INVOICE NO.	INVOICE DATE	AMOUNT
10-26-00	10/31/00	270.00

CHARGED TO:

ACCOUNT NO.	FUND	DEPT.	AMOUNT
2494	[illegible]	[illegible]	270.00

TOTAL ~~270.00~~ 270.00 THESE MUST EQUAL

DESCRIPTION OF ORDER:
individual psychotherapy

PAYMENT INSTRUCTIONS:

AUTHORIZED BY:

Accounting Use Only

ACCOUNTING:

ORIGINAL TO ACCOUNTING - MAKE A PHOTOCOPY FOR YOUR RECORDS

10-04-04 Order
0357

Bill To:
Reverend Robert Wilson
Catholic Diocese
800 West Loop 820 South
Fort Worth, TX 76108

Bill as of: Oct 31, 2000

Date	Transaction	Session Charge	Total Owed
10/2/2000	Individual Psychotherapy	$90.00	$90.00
10/9/2000	Individual Psychotherapy	$90.00	$90.00
10/16/2000	Individual Psychotherapy	$90.00	$90.00
		$270.00	$270.00

Please Pay this Amount: $270.00

THIS REFLECTS DATES OF SERVICE

10-04-04 Order
0358

Diocese of Fort Worth

10-27-07

I don't understand this bill. It treats the Diocese as an [illegible] company which we are not. [illegible] submit it to your insurance company. Send me the receipt or the copy of a check that you paid the doctor by co-insurance and I will reimburse you personally from the Diocese. Ex # [illegible] [illegible] you are still continuing payments through March 31, 2008.

[illegible]

The Catholic Center ~ [redacted] Worth, Texas 76108-2919 817/560-3300

10-04-04 Order
0359

[redacted]

CATHOLIC DIOCESE
REVEREND ROBERT WILSON
800 W. LOOP 820 SOUTH
FT WORTH, TX 76108

HEALTH INSURANCE CLAIM FORM

MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER: X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE / SEX: X
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED: X
ZIP CODE / TELEPHONE (Include Area Code)

a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. OTHER INSURED'S DATE OF BIRTH
c. EMPLOYER'S NAME OR SCHOOL NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / X NO
b. AUTO ACCIDENT? PLACE (State) YES / X NO
c. OTHER ACCIDENT? YES / X NO
10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH / SEX
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME: CATHOLIC DIOCESE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / X NO

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
SIGNED DATE 10/25/2000

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM / TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? $ CHARGES: YES / X NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: 1. 311
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From / To	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
9 25 2000 / 25 200	11		90801		175.00	1				

10-04-04 Order
0360

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT?
28. TOTAL CHARGE $ 175.00
29. AMOUNT PAID $
30. BALANCE DUE $ 175.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
SIGNED 0/25/200

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office): SAME

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 FORM OWCP-1500

October 29, 2000

Re: Your Note Dated 10/27/00,

You received that bill because has cancer, was in remission, and relapsed. He can no longer see patients, at least for now (I'm told, "indefinitely").

It angers me that I have to tell you about my most personal of problems, but in order for you to understand what has transpired, I see no other way. I went through a crisis that quite nearly had me hospitalized, one that had me contemplating suicide. was on the verge of having me institutionalized, but I promised her I wouldn't harm myself, and if those thoughts re-occurred, to call her immediately, and we'd go to the hospital. She then instructed me to call my physician without delay as she thought it might be medication related. Since was not available, I was put in contact with Office, to know the billing was set up.

I have used all my available physician benefits. And if you really want to get picky about it, I'll have office print up all the co-pays I made before office began sending them to you, which probably are in the range of $150 - $200.00.

I don't understand your reasoning for this. Nor do I appreciate the tone of your note. When I first began therapy and the abuse issue came out, I saw a therapist in

At that time she outlined what my options would be, and one of those options was monetary compensation for pain and suffering. She was quite serious about this. I told her I didn't want anything to do with your money. I just wanted my life back - the one that was so horrendously taken from me by a Catholic priest, someone I looked up to, and trusted. Someone who led many parishioners to believe what he said was the absolute truth, including my family. All the while leading a second, secret life, that as a pedophile. I am still angry for what he did to me, and all the years that have passed while I went on, making the same mistakes over and over, never realizing it was because of it. It's been that has shown me the path I must take, and I am determined to take it, even as difficult as it is, because I need to undo the damage done by "monsignor" Reilly. You cannot ever hope to know the extent of the disfigurement he did to my inner self. He affected every facet of my life, from interacting with my family and friends to having relationships with a significant other. I have lost friends along the way, because they couldn't understand why I acted the way I did. And I didn't understand it either. I am healing, and yes, it IS a slow process. Tearing down walls that have been up for thirty years is going to take some time. And therapy. And medication. And the bills that are inherent in such a monumental task

such as this. Eventually, I will have control over my life, and "he" won't.

It's amazing that, even though he's dead, he still exerts some control in my life.

When I have worked through this, and get my self esteem, among other things back, you'll be the first to know. Until such time, I don't expect to receive any more notes quibbling over a few dollars.

Sincerely,

Diocese of Fort Worth

Copy

November 10, 2000

Dear

Thank you for your letter of October 29. I am sorry that my inquiry caused you pain. It looked to me from the forms as though the psychiatrist's office had filed an insurance claim with us by mistake. Now that I understand the s[illegible] authorized the payment to Our finance office will also be sending the $15 copay you requested.

As I asked to tell you the Diocese of Fort Worth will continue to pay those counseling and related medical bills through March 31, 2001 at which time we will bring our relationship to a conclusion. At that time we will have exceeded our usual counseling allowance by a full year. However, we wanted to be of help to you.

I am very sorry for your pain and hope that our support of the counseling has been of help and will be through next March.

Be assured of my prayers.

Sincerely yours in Christ,

Rev. Robert W. Wilson
Chancellor, Moderator of the Curia

10-04-04 Order
0363

The Catholic Center
800 West Loop 820 South • Fort Worth, Texas 76108-2919 • 817/560-3300 • Fax 817/244-8839

CATHOLIC DIOCESE OF FORT WORTH

PAYMENT ORDER / ACCOUNTS PAYABLE VOUCHER FORM

Accounting Use Only

VENDOR NO.: ENTERED BY/DATE:

DATE: 11-16-04 TAX PAYER ID NO.:

PLEASE PAY TO: PAYMENT IS RELATED TO:

- DIOCESE
- FOUNDATION

INVOICES TO BE PAID

INVOICE NO.	INVOICE DATE	AMOUNT
N/A	9-25-04	175.00
"	10-26-04	70.00
		245.00
		$0.00

CHARGE TO

ACCOUNT NO.	FUND		AMOUNT
7588.01	01	8571	175.00
"	"	"	70.00
			$245.00
			$0.00

THESE MUST EQUAL

DESCRIPTION OF ORDER: Counseling

One Check

PAYMENT INSTRUCTIONS: Put above dates and

AUTHORIZED BY:

Accounting Use Only

ACCOUNTING:

ORIGINAL TO ACCOUNTING - MAKE A PHOTOCOPY FOR YOUR RECORDS

10-04-04 Order
0364

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CATHOLIC DIOCESE
REVEREND ROBERT WILSON
800 W. LOOP 820 SOUTH
FT WORTH, TX 76108

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
						X

1a. INSURED'S I.D. NUMBER

PATIENT'S NAME (Last Name, First Name, Middle Initial)

INSURED'S NAME (Last Name, First Name, Middle Initial)

PATIENT'S ADDRESS (No., Street)

PATIENT RELATIONSHIP TO INSURED: Self

INSURED'S ADDRESS (No., Street)

CITY

STATE

PATIENT STATUS: Single

ZIP CODE

TELEPHONE (INCLUDE AREA CODE)

OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

IS PATIENT'S CONDITION RELATED TO:

INSURED'S POLICY GROUP OR FECA NUMBER

OTHER INSURED'S POLICY OR GROUP NUMBER

EMPLOYMENT? (CURRENT OR PREVIOUS): NO

INSURED'S DATE OF BIRTH

OTHER INSURED'S DATE OF BIRTH

AUTO ACCIDENT? NO

EMPLOYER'S NAME OR SCHOOL NAME

OTHER ACCIDENT? NO

INSURANCE PLAN NAME OR PROGRAM NAME: CATHOLIC DIOCESE

RESERVED FOR LOCAL USE

IS THERE ANOTHER HEALTH BENEFIT PLAN? NO

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

10/25/2000

SIGNED

DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

PATIENT HAS HAD SAME OR SIMILAR ILLNESS

DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

ID. NUMBER OF REFERRING PHYSICIAN

HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO

RESERVED FOR LOCAL USE

OUTSIDE LAB? NO

$ CHARGES

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

311

MEDICAID RESUBMISSION CODE

ORIGINAL REF. NO.

PRIOR AUTHORIZATION NUMBER

A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
9 25 2000	25 206	11		90801			175.00	1				

10-04-04 Order
0365

FEDERAL TAX I.D. NUMBER: SSN EIN

PATIENT'S ACCT. NO.

ACCEPT ASSIGNMENT?

TOTAL CHARGE: $ 175.00

AMOUNT PAID: $

BALANCE DUE: $ 175.00

SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

0/25/200

NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SAME

PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)

PLEASE DO NOT STAPLE IN THIS SPACE

[redacted]

CATHOLIC DIOCESE
REVEREND ROBERT WILSON
800 W. LOOP 820 SOUTH
FT WORTH, TX 76108

HEALTH INSURANCE CLAIM FORM

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
		(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	X (ID)

11. INSURED'S I.D. NUMBER — (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE — SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED — Self X — Spouse — Child — Other

7. INSURED'S ADDRESS (No., Street)

CITY — STATE

ZIP CODE — TELEPHONE (Include Area Code)

ZIP CODE — TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH — SEX

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) — YES — NO X

b. AUTO ACCIDENT? — PLACE (State) — YES — NO X

c. OTHER ACCIDENT? — YES — NO X

a. INSURED'S DATE OF BIRTH — SEX

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME
CATHOLIC DIOCESE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? — YES — NO X — If yes, return to and complete item 9 a-d.

12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM
PATIENT'S AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED — DATE 10/30/2000

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? — YES — NO X — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 311
2.
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
10 26 2000	10 26 2000		1	90862		1	70.00	1				

10-04-04 Order
0366

25. FEDERAL TAX I.D. NUMBER — SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)

28. TOTAL CHARGE $ 70.00

29. AMOUNT PAID $

30. BALANCE DUE $ 70.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
I certify that the statements on the reverse apply to this bill and are made a part thereof.

SIGNED 10/30/2000

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

SAME

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

PIN# GRP#

700-0120 (7000) (OCR)

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/81

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

CATHOLIC DIOCESE OF FORT WORTH

PAYMENT ORDER / ACCOUNTS PAYABLE VOUCHER FORM

Accounting Use Only

VENDOR NO.: ENTERED BY/DATE:

DATE: 11-10-04 TAX PAYER ID NO.:

PLEASE PAY:

PAYMENT RELATES TO:
- [X] DIOCESE
- [ ] FOUNDATION

INVOICES TO BE PAID			CHARGE TO:		
INVOICE NO.	INVOICE DATE	AMOUNT	ACCT.	DEPT.	AMOUNT
11-11	11-31-00	15.00	5800	01	15.00
		$0.00			$0.00

THESE MUST EQUAL

DESCRIPTION OF ORDER: Counseling

COMMENTS:

AUTHORIZED BY: Rev

Accounting Use Only

ACCOUNTING:

ORIGINAL TO ACCOUNTING - MAKE A PHOTOCOPY FOR YOUR RECORDS

10-04-04 Order
0367

October 31, 2000

Please find enclosed the receipts for my most recent medications. Consider this as an invoice for same.

Wellbutrin, 90tabs, $15.00

Total: $15.00

Thank you,

10-04-04 Order
0368

CATHOLIC DIOCESE OF FORT WORTH

PAYMENT ORDER / ACCOUNTS PAYABLE VOUCHER FORM

Accounting Use Only

VENDOR NO.: ENTERED BY/DATE:

DATE: 1-12-07 TAX PAYER ID NO.:

PLEASE PAY TO:

PAYMENT RELATES TO:
- [X] DIOCESE
- [ ] FOUNDATION

INVOICES TO BE PAID			CHARGE TO:		
INVOICE NO.	INVOICE DATE	AMOUNT	ACCOUNT NO.		AMOUNT
N/A	11-30-06	180.00	8588-01-8571		180.00
		$0.00			$0.00

THESE MUST EQUAL

DESCRIPTION OF ORDER: Counseling

PAYMENT INSTRUCTIONS:

AUTHORIZED BY: [signature]

Accounting Use Only

ACCOUNTING:

ORIGINAL TO ACCOUNTING - MAKE A PHOTOCOPY FOR YOUR RECORDS

10-04-04 Order
0369

[redacted]

Bill To:
Reverend Robert Wilson
Catholic Diocese
800 West Loop 820 South
Fort Worth, TX 76108

Bill as of: Nov 30, 2000

Date	Transaction	Session Charge	Total Owed
11/3/2000	Individual Psychotherapy	$90.00	$90.00
11/17/2000	Individual Psychotherapy	$90.00	$90.00
		$180.00	$180.00

Please Pay this Amount: $180.00

This bill refects dates of service for

10-04-04 Order
0370

CATHOLIC DIOCESE OF FORT WORTH

PAYMENT ORDER / ACCOUNTS PAYABLE VOUCHER FORM

Accounting Use Only

VENDOR NO.: ENTERED BY/DATE:

DATE: 12-15-00 TAX PAYER ID NO.:

PLEASE PAY TO:

PAYMENT RELATES TO:
[X] DIOCESE
[ ] FOUNDATION

INVOICES TO BE PAID

INVOICE NO.	INVOICE DATE	AMOUNT
12-14-00	12-11-00	15.00
		15.00

CHARGE TO:

ACCOUNT NO.	FUND	DEPT.	AMOUNT
[illegible]	01	8[illegible]	15.00
			15.00

THESE MUST EQUAL

DESCRIPTION OF ORDER: Medication Co-Pay

PAYMENT INSTRUCTIONS:

AUTHORIZED BY: [signature]

Accounting Use Only

ACCOUNTING:

[illegible] - DIO AP

ORIGINAL TO ACCOUNTING - MAKE A PHOTOCOPY FOR YOUR RECORDS

10-04-04 Order
0371