

CATHOLIC DIOCESE OF FORT WORTH

REQUEST FOR REIMBURSEMENT

Payment

Accounting Use Only

VENDOR NO.	ENTERED BY/DATE
------------	-----------------

PLEASE PAY TO:	9-10-99

PAYMENT REQUEST TO
DIOCESE
FOUNDATION

PAID INVOICES (ATTACHED):		CHARGED TO:			
DESCRIPTION	AMOUNT	ACCOUNT NO.	FUND	DEPT.	AMOUNT
<i>Counseling</i>	<i>270.00</i>	<i>0888 00</i>	<i>001</i>	<i>8531</i>	<i>270.00</i>

DOCUMENT IS NOT TO BE REPRODUCED.

SUB-TOTAL INVOICES
 LESS - ADVANCES DUE
 NET REIMBURSEMENT TO USER

270.00

SUB-TOTAL ACCOUNTING
 LESS - ADVANCES DUE
 TOTAL ACCOUNTING

270.00

THESE MUST EQUAL

PAYMENT INSTRUCTIONS:	
REQUESTED BY:	<i>[Signature]</i>
AUTHORIZED BY:	<i>[Signature]</i>

10-04-04 Order
0285

Accounting Use Only	
ACCOUNTING:	

FORM 100-100

5/10/94 - DIO REM

ORIGINAL TO ACCOUNTING - MAKE A PHOTOCOPY FOR YOUR RECORDS

PER COURT ORDER - DOCUMENT NOT TO BE DISCLOSED TO ANYONE NOT IDENTIFIED IN SUCH ORDER AND INFORMATION IN DOCUMENT ONLY TO BE USED IN CAUSE NO. 141-198356-03, TARRANT COUNTY, TEXAS. THIS DOCUMENT IS NOT TO BE

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

Bill as of: Sep 1, 1999

Date	Transaction	Session Charge	Total Owed
	Previous Balance		\$270.00
8/6/99	Individual Psychotherapy	\$90.00	\$90.00
8/12/99	Individual Psychotherapy	\$90.00	\$90.00
8/19/99	Individual Psychotherapy	\$90.00	\$90.00
8/26/99	Payment - Reverend Bob Wilson		(\$270.00)
		\$270.00	\$270.00

Please Pay this Amount:

This bill is for the above date of service for
Thank you

CATHOLIC DIOCESE OF FORT WORTH
PAYMENT ORDER / ACCOUNTS PAYABLE VOUCHER FORM

Accounting Use Only

VENDOR NO. _____ ENTERED BY/DATE _____

DATE: 10-8-99 TAXPAYER ID NO. _____

PAYMENT RELATES TO
 BUDGET
 FOUNDATION

INVOICES TO BE PAID			CHARGE TO			
INVOICE NO.	INVOICE DATE	AMOUNT	ACCOUNTING	FUND	DEPT.	AMOUNT
<u>N/A</u>	<u>10-1-99</u>	<u>360</u>	<u>780300</u>	<u>0000</u>	<u>0000</u>	<u>360</u>

DOCUMENT NOT TO BE REPRODUCED

THESE ARE EQUAL

DESCRIPTION OF ORDER:
Accounting

PAYMENT INSTRUCTIONS:

APPROVED BY: Paul

Accounting Use Only
 ACCOUNTING: _____

ORIGINAL TO ACCOUNTING - MAKE A PHOTOCOPY FOR YOUR RECORDS

10-04-04 Order
 0287

CATHOLIC DIOCESE OF FORT WORTH

PAYMENT ORDER / ACCOUNTS PAYABLE VOUCHER FORM

Accounting Use Only

YZNDOR NO: _____ ENTERED BY/DATE: _____

DATE: 7/1/99 TAXPAYER ID NO: _____

PLEASE PRINT: _____
PAYMENT RELATES TO:
 DIOCESE
 FOUNDATION

INVOICES TO BE PAID			CHARGE			
INVOICE NO.	INVOICE DATE	AMOUNT	ACCOUNT NO.	FUND	DEPT.	AMOUNT
	<u>Nov 7, 1997</u>	<u>270.00</u>	<u>7869 A</u>	<u>01</u>	<u>8571</u>	<u>270.00</u>

DOCUMENT IS NOT TO BE REPRODUCED.

DESCRIPTION OF ORDER:
Operating

PAYMENT INSTRUCTIONS:

AUTHORIZED BY: [Signature]

Accounting Use
ACCOUNTING: _____

ORIGINAL TO ACCOUNTING - MAKE A PHOTOCOPY FOR YOUR RECORDS

10-04-04 Order
0289

Bill To:

Reverend Bob Wilson
Catholic Diocese
800 West Loop East, South
Fort Worth, TX 76108

Billed on: Nov 1, 1999

Date	Transaction	Session Charge	Total Owed
	Previous Balance		\$360.00
10/9/99	Individual Psychotherapy	\$90.00	\$90.00
10/14/99	Payment - Reverend Bob Wilson		(\$360.00)
10/23/99	Individual Psychotherapy	\$90.00	\$90.00
10/27/99	Individual Psychotherapy	\$90.00	\$90.00
		\$270.00	\$270.00

DOCUMENT IS NOT TO BE REPRODUCED

This bill is for \$270.00. If you have any questions, please feel free to call.

Thank you.

10-04-04 Order
0290

CATHOLIC DIOCESE OF FORT WORTH

PAYMENT ORDER/ACCOUNTSPAYABLE/VOUCHER FORM

Accounting Use Only

VENDOR NO. _____ ENTERED BY/DATE: _____

DATE: 12-2-99 TAXPAYER ID NO. _____

PLEASE PAY TO: _____

PAYMENT RELATES TO:
 DIOCESE
 FOUNDATION

INVOICES TO BE PAID			CHARGE TO:	
INVOICE NO.	INVOICE DATE	AMOUNT	ACCOUNT NO.	AMOUNT
<u>11/11</u>	<u>11-30-99</u>	<u>360.00</u>	<u>7885</u>	<u>360.00</u>

DOCUMENT IS NOT TO BE REPRODUCED

THESE MUST EQUAL

DESCRIPTION OF ORDER:
Excessing

PAYMENT INSTRUCTIONS:

AUTHORIZED BY: [Signature]

Accounting Use Only
ACCOUNTING: _____

ORIGINAL TO ACCOUNTING - MAKE A PHOTOCOPY FOR YOUR RECORDS

10-04-04 Order
0291

Bill To:

Reverend Bob Wilson
Catholic Diocese
800 West Loop 820 South
Fort Worth, TX 76108

Bill as of: Nov 30, 1999

Date	Transaction	Session Charge	Total Owed
	Previous Balance		\$270.00
11/3/99	Individual Psychotherapy	\$90.00	\$90.00
11/10/99	Individual Psychotherapy	\$90.00	\$90.00
11/12/99	Payment - Reverend Bob Wilson		(\$270.00)
11/17/99	Individual Psychotherapy	\$90.00	\$90.00
11/23/99	Individual Psychotherapy	\$90.00	\$90.00
		\$360.00	\$360.00

Please Pay this Amount:

This bill reflects the charges for
services rendered. If you have any questions, please feel
free to call.
Thank you.

If you have any questions, please feel

10-04-04 Order
0292

December 23, 1999

Robert Wilson
Catholic Diocese
Fort Worth, Texas

Please consider this letter as an invoice for my prescribed medicines. Enclosed are the receipts.

Remeron 30 mg Tablets #60	\$141.99
Clonazepam 2mg Tablets #60	\$15.99
Total:	\$157.98

Your prompt remittance would be greatly appreciated.

Sincerely,

10-04-04 Order
0293

CATHOLIC DIOCESE OF FORT WORTH

PAYMENT ORDER / ACCOUNTS PAYABLE VOUCHER FORM

Accounting Use Only

VENDOR NO. _____ ENTERED BY DATE _____

DATE: 1-3-98 TAXPAYER NO. _____

PLEASE PAY TO: _____

PAYMENT RELATED TO:
 DIOCESE
 FOUNDATION

INVOICES TO BE PAID			CHARGE TO			
INVOICE NO.	INVOICE DATE	AMOUNT	ACCOUNT NO.	FUND	DEPT.	AMOUNT
<u>111</u>	<u>1-3-98</u>	<u>197.98</u>	<u>7888.00</u>	<u>857A</u>		<u>197.98</u>

DOCUMENT IS NOT TO BE REPRODUCED.

DESCRIPTION OF ORDER:

PAYMENT INSTRUCTIONS:

AUTHORIZED BY:

ACCOUNTING:

ORIGINAL TO ACCOUNTING - MAKE A PHOTOCOPY FOR YOUR RECORDS

10-04-04 Order
0294

January 6, 2000

Memo to Files

From: Father Wilson

In re:

I spoke with [redacted] today, telling him of having paid for more than six months of counseling for [redacted] and how he wants us to pay for his anti-depressant drugs and his psychiatric bills, as well as his therapist. I agreed to do so for one month, but have sent him waiver sheets for the therapist, [redacted] and the psychiatrist so that they can give me a report. I have also written [redacted] saying that I will have to sit down with him to learn what he is accusing Monsignor James Reilly of having done when he was a child.

DOCUMENT IS NOT TO BE REPRODUCED.

CONFIDENTIAL

10-04-04 Order
0295

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

Bill as of: Dec 30, 1999

Date	Transaction	Session Charge	Total Owed
	Previous Balance		\$360.00
12/1/99	Individual Psychotherapy	\$90.00	\$90.00
12/8/99	Individual Psychotherapy	\$90.00	\$90.00
12/9/99	Payment		(\$360.00)
12/15/99	Individual Psychotherapy	\$90.00	\$90.00
12/22/99	Individual Psychotherapy	\$90.00	\$90.00
12/29/99	Individual Psychotherapy	\$90.00	\$90.00
		\$450.00	\$450.00

Please Pay this Amount:

This bill reflects the dates of service for
please feel free to call.

if you have any questions

10-04-04 Order
0297



January 6, 2000

Dear _____

I am sure that _____ told you that I have authorized a month of therapy from me, as well as one month of therapy from your psychiatrist, along with medication. I am authorizing payment for the two prescriptions, for which you sent me the receipt. One for \$149.99. The other is for \$55.99. The reimbursement will be sent from our finance office. I assume that since there are sixty tablets in each prescription, both are two month prescriptions.

I am enclosing six copies of a form that we are adapting as a standard in the diocese. Please sign all six copies in the presence of a witness, who is also to sign each form.

Please fill in the name of each of your two therapists on three sheets. One copy should be sent to me, one copy given to the therapist and one kept for your records.

For the diocese to authorize further payments, it will be necessary to receive answers to the questions listed from _____ and the psychiatrist. In addition you and I will have to sit down and discuss what happened and your prognosis. If you wish please feel free to bring someone with you for the interview.

With best wishes, and with prayer for your speedy recovery, I am

Sincerely yours in Christ,

Robert W. Wilson

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

RW/caw

Enc.

Cc:

*I am sending a copy of this letter to _____ but since I do not know the name of your psychiatrist, I am unable to send one to him. Please give him a copy of this letter if you like.

10-04-04 Order
0298

The Catholic Center

800 West Loop 320 South - Fort Worth, Texas 76108-2919 • 817/560-3300 • Fax 817/244-3839

PER COURT ORDER - DOCUMENT NOT TO BE DISCLOSED TO ANYONE NOT IDENTIFIED IN SUCH ORDER AND INFORMATION IN DOCUMENT ONLY TO BE USED IN CAUSE NO. 141-198356-03, TARRANT COUNTY, TEXAS. THIS DOCUMENT IS NOT TO BE

Diocese of Fort Worth VICTIMS ASSISTANCE MINISTRY
CONSENT TO RELEASE INFORMATION

For the purpose of the treatment being provided me, I hereby give permission to _____ to release report concerning my treatment as itemized below to the Diocese of Fort Worth. The information released will be confidential, and available only to the bishop of the Diocese of Fort Worth, the Vicar General and the Chancellor, and as necessary to committee members of the Committee on Implementation of the Diocesan Policy on Sexual Misconduct. These recipients may disclose this information as necessary in consulting with mental health professionals who specialize in areas relevant to my treatment. (Otherwise, no further redisclosure by these recipients is authorized without my specific written consent.)

The written report to which I give consent shall include, but not be limited to the following:

- An initial diagnostic formulation
- Treatment orientation/model
- Initial treatment plan and goals
- A periodic progress review of treatment
- Any medication or psychiatric/medical consultation
- Changes in treatment planning and goals
- Recommendations

I also authorize _____ to respond to all questions of one or the above-mentioned officials of the Diocese of Fort Worth concerning these aspects of my treatment, whether oral or written.

I recognize my right to inspect and copy, if I so choose, all records and other written information to be disclosed pursuant to this consent.

I expressly reserve the right to revoke my consent at any time by giving written notice of revocation to all parties named in this form. Any such revocation will have no effect upon disclosures properly made prior to the revocation. Unless earlier revoked by me, this time limited consent to release of information shall remain in effect twelve (12) months from the date that I have signed it.

My signature below indicates that I have carefully reviewed this consent form and freely consent to the disclosure of the records and information as specified above.

Date

Consenting Party's Signature

Consenting Party's Name Printed

Witness' Signature

Witness' Name Printed

Please return this form to:

Rev. Robert W. Wilson, Chancellor and Moderator of the Curia
 Diocese of Fort Worth
 800 West Loop 820 South
 Fort Worth, Texas 76108

(817) 560-3300

10-04-04 Order
 0299

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

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R. J. Jones
1-10-00

January 10, 2000

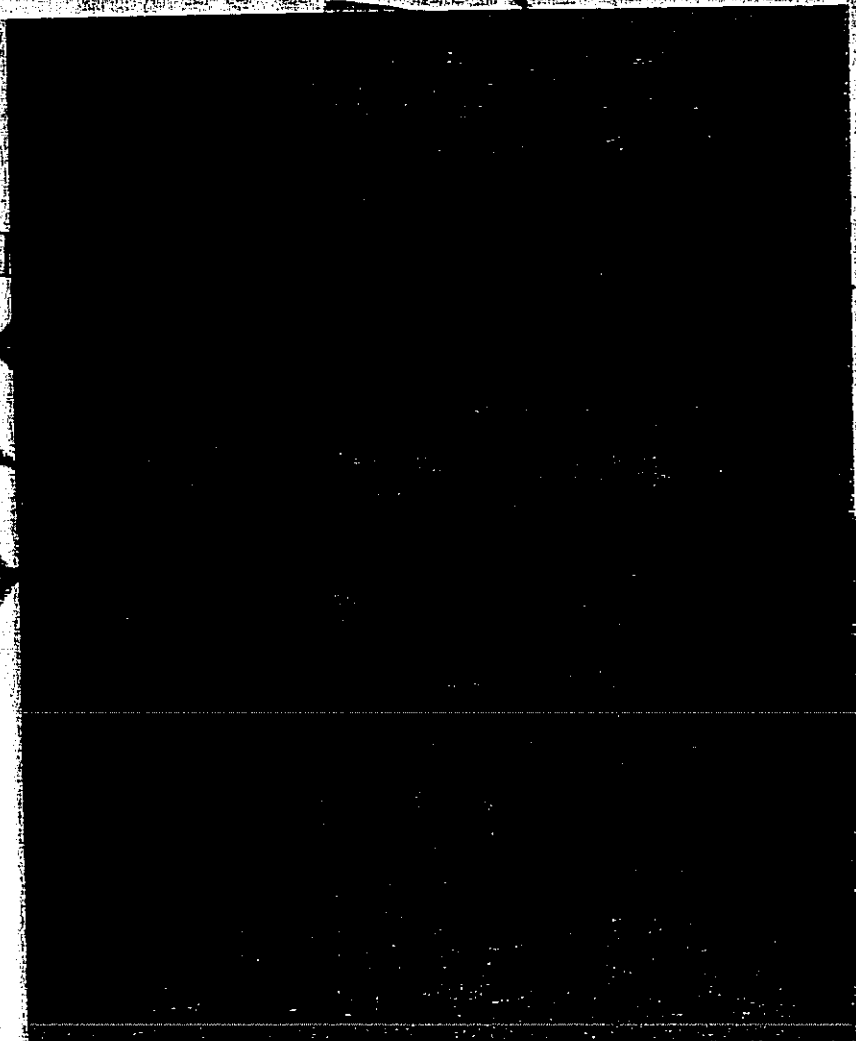
As per your instructions, I have enclosed the consent forms, and forwarded the proper copies to my therapists.

It should be noted that the prescriptions are for one, not two months.

I must tell you that I would feel more than a little uncomfortable discussing with you, or any Catholic clergy what happened.

Sincerely,

CONFIDENTIAL



CONFIDENTIAL DOCUMENT

10-04-04 Order
0300

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Diocese of Fort Worth

VICTIMS ASSISTANCE MINISTRY
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- Changes in treatment planning and goals
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[Signature]
Date: _____

Consenting Party's Signature

Consenting Party's Name Printed

[Signature]
Date: _____

Witness' Signature

Witness' Name Printed

Please return this form to:

Rev. Robert W. Wilson, Chancellor and Moderator of the Curia
Diocese of Fort Worth
800 West Loop 820 South
Fort Worth, Texas 76108

10-04-04 Order
0301

(817) 560-3300

The Catholic Center

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

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Diocese of Fort Worth

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- A periodic progress review of treatment
- Any medication or psychiatric/medical consultation
- Changes in treatment planning and goals
- Recommendations

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My signature below indicates that I have carefully reviewed this consent form and freely consent to the disclosure of the records and information as specified above.

9/20/04
Date

Consenting Party's Signature

Consenting Party's Name Printed

10/6/04
Date

Witness Signature

Witness Name Printed

Please return this form to:

Rev. Robert W. Wilson, Chancellor and Moderator of the Curia
Diocese of Fort Worth
800 West Loop 820 South
Fort Worth, Texas 76108

(817) 560-3300

10-04-04 Order
0302

The Catholic Center

800 West Loop 820 South • Fort Worth, Texas 76108 • 817/560-3300 • Fax 817/244-8830

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Account Number

Date
01/07/00

Date	Patient	Procedure	Trans Detail	Total Insur Payment	Total Patient Payment	Patient Balance
08/23/99		PAYMENT ON ACCOUNT				
09/23/99		PAYMENT ON ACCOUNT	-20.00			
09/23/99		PAYMENT ON ACCOUNT	-5.00			
11/22/99		OP-MEDICATION MANAGE	-60.00			
11/22/99	29622	MAJOR DEPRESSIVE DIS		0.00	15.00	0.00
11/22/99		PAYMENT ON ACCOUNT	15.00			
11/29/99		INSURANCE PAYMENT	-91.91			
11/29/99		INSURANCE ADJUSTMENT	-63.09			
11/29/99		INSURANCE PAYMENT	-35.21			
11/29/99		INSURANCE ADJUSTMENT	-4.79			
01/07/00		OP-MEDICATION MANAGE	60.00	0.00	0.00	60.00
	29622	MAJOR DEPRESSIVE DIS				

DOCUMENT IS NOT TO BE REPRODUCED

Insurance was last billed on 11/22/99

Total Balance		100.00					
Total Due From Insurance		-	45.00				
Total Patient Balance		=	55.00				
CURRENT BAL	30 DAY BAL	60 DAY BAL	90 DAY BAL	120 DAY BAL			
PT 55.00	0.00	0.00	0.00	0.00			Please Pay
IN 0.00	45.00	0.00	0.00	0.00			55.00

10-04-04 Order
0304