CHECK REQUEST

DATE: August 8, 2000

PAYEE (VENDOR) Edna L. Moses LCSW
5041 Rocoso Way
Santa Barbara, CA 93111

VENDOR #

AMOUNT $ 3,920.00

REASON: Counseling expenses for [redacted]

DEPARTMENTAL APPROVAL _____

OFFICE OF THE BISHOP -#450

VENDOR #_____

INVOICE #

DISTRIBUTION

A/C# AMT $

A/C# AMT $

A/C# AMT $

A/C# AMT $

ACCT APPROVAL

_____

50600818

E DO NOT
APLE IN
S AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED OMB NO. 0938-0008

MEDICARE (MEDICARE NO.) | MEDICAID (MEDICAID NO.) | CHAMPUS (SPONSOR'S SSN) | CHAMPVA (VA FILE NO.) | FECA BLACK LUNG (SSN) | OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) — [redacted]
2. PATIENT'S DATE OF BIRTH — [redacted]
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) — [redacted]
5. PATIENT'S SEX — MALE [X] FEMALE [ ]
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS) — [redacted]
7. PATIENT'S RELATIONSHIP TO INSURED — SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
   [ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. PHONE NO. — [redacted]
   OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND CLAIM NUMBER AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)
10. WAS CONDITION RELATED TO:
    A. PATIENT'S EMPLOYMENT — YES [ ] NO [ ]
    B. ACCIDENT — AUTO [ ] OTHER [ ]
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
    TELEPHONE NO.
11a. CHAMPUS SPONSOR'S
    STATUS — ACTIVE DUTY [ ] RETIRED [ ] DECEASED [ ]
    BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
    I AUTHORIZE THE RELEASE OF ANY MEDICAL 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 [redacted] DATE 7-20-00
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW. [redacted]
    SIGNED INSURED OR AUTHORIZED PERSON

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
16a. IF EMERGENCY CHECK HERE [ ]
17. PATIENT ABLE TO WORK TO WORK
18. DATES OF TOTAL DISABILITY — FROM — THROUGH
    DATES OF PARTIAL DISABILITY — FROM — THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (eg. PUBLIC HEALTH AGENCY)
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES — ADMITTED — DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES:
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE — [redacted]
    B. EPSDT YES [ ] NO [ ]
    FAMILY PLANNING YES [ ] NO [ ]
    PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. * T.O.S.	H. LEAVE BLANK
3-16-00		0	90806	Individual therapy	[redacted]	140 —	1		
3-23-00		0	90806	"	[redacted]	140 —	1		
3-30-00		0	90806	"		140 —	1		
4-6-00		"	90806	"		140 —	1		
4-13-00		"	90806	"		140 —	1		
4-20-00		"	90806	"		140 —	1		

25. 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)
    Edna Moses
    DATE 7/20/00
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [ ] NO [ ]
27. TOTAL CHARGE 840 —
28. AMOUNT PAID —0— |
29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO. — [redacted]
31. PHYSICIAN'S, SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.
    805-683-6702
    Edna Moses
    5041 Rocoso Way
    Santa Barbara CA 93111
    I.D. NO.
32. YOUR PATIENT'S ACCOUNT NO.
33. YOUR EMPLOYER I.D. NO.
    SAME

* (SEE INSTRUCTIONS FOR PLACE OF SERVICE (T.O.S.) CODES ON THE BACK)

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 5/83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500 Form RRB-1500
Form CHAMPUS-501

5 0 6 0 0 0 4 0

DO NOT
E IN
AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED OMB NO. 0938-0008

MEDICARE | MEDICAID (MEDICAID NO.) | CHAMPUS (SPONSOR'S SSN) | CHAMPVA (VA FILE NO.) | FECA BLACK LUNG (SSN) | OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) [redacted]
2. PATIENT'S [redacted]
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) [redacted]
5. PATIENT'S SEX: MALE [X] FEMALE [ ]
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS) [redacted]
7. PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. INSURED'S GROUP NO. (FOR GROUP NAME OR FECA CLAIM NO.) — [ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. [redacted] NO. — HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)
10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT: YES [ ] NO [ ]; B. ACCIDENT: AUTO [ ] OTHER [ ]
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE) — TELEPHONE NO.
11a. CHAMPUS SPONSOR'S [redacted] — STATUS: ACTIVE DUTY [ ] DECEASED [ ] RETIRED [ ] — BRANCH OF SERVICE
12. I AUTHORIZE [redacted] — SIGNED
13. [redacted] OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW. — DATE 7/20/00 — SIGNED [redacted]

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES — 16a. IF EMERGENCY CHECK HERE [ ]
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (eg. PUBLIC HEALTH AGENCY)
17a. I.D. NO.
18. DATES PATIENT UNABLE TO WORK — FROM — THROUGH
19. DATES OF PARTIAL DISABILITY — FROM — THROUGH
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES — ADMITTED — DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. * WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES:

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE — [redacted]

EPSDT YES [ ] NO [ ]
FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO.

A. DATE OF SERVICE FROM	TO	B. * PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. * EMG	H. LEAVE BLANK
4/27/00		0	90806	Individual therapy	[redacted]	140	1		
5/4/00		11	90806	"		210	1.5		
5/11/00		"	90806	"		210	1.5		
5/18/00		"	90806	"		210	1.5		
5/25/00		"	90806	"		210	1.5		
6/1/00		"	90806/10847	individual & couple therapy		210	1.5		

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF) — Edna Moss — DATE 7/20/00
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [ ] NO [ ]
28. TOTAL CHARGE 1140
29. AMOUNT PAID 2
30. BALANCE DUE
30. YOUR SOCIAL SECURITY NO. [redacted]
31. PHYSICIAN'S, SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO. 805-683-6702 — Edna Moses, 5041 Rocoso Way, Santa Barbara CA 93111
32. YOUR EMPLOYER I.D. NO. SAME
I.D. NO.

* SEE INSTRUCTIONS AND TYPE OF SERVICE (TOS) CODES ON THE BACK

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

5060090

DO NOT [redacted]
LE IN
AREA

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED OMB NO. 0938-0008

[ ] MEDICARE (MEDICARE NO.) [ ] MEDICAID (MEDICAID NO.) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO.) [ ] FECA BLACK LUNG (SSN) [ ] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) [redacted]
2. PATIENT'S DATE OF BIRTH [redacted]
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) [redacted]
5. PATIENT'S SEX: MALE [X] FEMALE [ ]
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE. INCLUDE ALL LETTERS) [redacted]
7. PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
9. INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN [ ]
10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT? YES [ ] NO [ ]; B. ACCIDENT? AUTO [ ] OTHER [ ]
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
12. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO [redacted]
13. 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. [redacted]
SIGNATURE OF PATIENT OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) — DATE 7/20/00 — SIGNED INSURED OR AUTHORIZED PERSON

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES
16.a. IF EMERGENCY CHECK HERE [ ]
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)
17.a. I.D. NO.
18. DATES OF TOTAL DISABILITY: FROM — THROUGH
19. DATES OF PARTIAL DISABILITY: FROM — THROUGH
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED — DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES:

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE [redacted]

EPSDT YES [ ] NO [ ]
FAMILY PLANNING YES [ ] NO [ ]
PRIOR AUTHORIZATION NO.

A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. * T.O.S.	H. LEAVE BLANK
6/8/00		0	90806/90847		[redacted]	210	1,3		
6/15/00		"	"		[redacted]	280	2		
6/22/00		"	90806/90847			280	2		
6/29/00		"	"			280	2		
7/6/00		"	"			280	2		
7/12/00		"	"						

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES) OR (I PLEASE) I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF.) Edna Moses
DATE 7-20-00
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [ ] NO [ ]
27. TOTAL CHARGE 1610
28. AMOUNT PAID 0
29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO. [redacted]
31. PHYSICIAN'S, SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO. 805-683-6702
Edna Moses
5041 Rocoso Way
Santa Barbara CA 93111
32. YOUR PATIENT'S ACCOUNT NO.
33. YOUR EMPLOYER I.D. NO. SAME
I.D. NO.

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/82

Form HCFA-1500 (C-2) (1-84) Form CWCP-1500
Form CHAMPUS-501 Form RRB-1500

5068004

DO NOT
LE IN
AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

FORM APPROVED OMB NO. 0938-0008

[ ] MEDICARE (MEDICARE NO.) [ ] MEDICAID (MEDICAID NO.) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO.) [ ] FECA BLACK LUNG (SSN) [ ] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) [redacted]

2. PATIENT'S DATE OF BIRTH [redacted]

3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) [redacted]

5. PATIENT'S SEX: MALE [X] FEMALE [ ]

6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS) [redacted]

7. PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]

8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)

[redacted] [ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9. OTHER INSURED'S NAME, POLICY OR GROUP NO., OR OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICY HOLDER IF DIFFERENT FROM PATIENT)

10. WAS CONDITION RELATED TO:

A. PATIENT'S EMPLOYMENT? YES [ ] NO [ ]

B. ACCIDENT? AUTO [ ] OTHER [ ]

11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO.

11A. CHAMPUS SPONSOR'S:

STATUS: ACTIVE DUTY [ ] DECEASED [ ] RETIRED [ ] BRANCH OF SERVICE

12. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN/SUPPLIER FOR SERVICES DESCRIBED BELOW. [redacted]

SIGNED

13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW. [redacted]

DATE 7-20-00

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES

16A. # EMERGENCY CHECK HERE [ ]

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY: FROM THROUGH

DATES OF PARTIAL DISABILITY: FROM THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (eg. PUBLIC HEALTH AGENCY)

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

22. * WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES:

23. PRIOR AUTHORIZATION NO.

24. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE [redacted]

EPSDT [ ] YES [ ] NO

FAMILY PLANNING [ ] YES [ ] NO

24. A. DATE OF SERVICE FROM	TO	B. * PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. * T.O.S.	H. LEAVE BLANK
7/20/00		0	90807/90847	Individual/couple therapy	[redacted]	280	2		

25. 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)

Edna Moses

DATE 7/20/00

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [ ] NO [ ]

27. TOTAL CHARGE 280.-

28. AMOUNT PAID 0

29. BALANCE DUE

30. YOUR SOCIAL SECURITY NO. [redacted]

31. PHYSICIAN'S, SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.

805-683-6702

Edna Moses
5041 Rocoso Way
Santa Barbara CA 93111

32. YOUR PATIENT'S ACCOUNT NO.

33. YOUR EMPLOYER I.D. NO. SAME

I.D. NO.

(SEE BACK FOR CODES ON THE BACK)

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 5/83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

5067C822

DIOCESE OF ORANGE

OFFICE OF VICAR GENERAL /
MODERATOR THE CURIA
MARYWOOD CENTER
P.O BOX 14195
2811 E. VILLA REAL DRIVE
ORANGE, CALIFORNIA 92863-1595
PHONE (714) 282-3000
EMAIL: msgr.jurell@rcbo.org
FAX (714) 282-3029

July 28, 2000

Edna L. Moses, LCSW
5041 Rocoso Way
Santa Barbara, California 93111

Dear Ms. Moses,

Thank you for your letter, dated July 20, 2000, which arrived in my office yesterday. I will attend to it upon my return from some vacation, which will be Tuesday, August 8, 2000.

I know that I will want to speak with you about the "Couple Therapy" and whether or not the Diocese of Orange will assist financially for that. (If [redacted] and his girlfriend were married, that would be a different situation). There are some issues of concern that "Couple Therapy" raises which you and I must discuss.

I will process the bills, through July 20, 2000, for payment upon my return.

Thanking you for your assistance to [redacted] I am

Sincerely yours in Christ,

COPY

Reverend Monsignor John Urell, V.G.
Vicar General / Moderator of the Curia

50600823

PHONE MEMO

TO	Mary Hull	DATE 8/08	TIME 9:00 AM PM
FROM	Edna Moses	AREA CODE 805	
OF		NO. 683-6702	
		EXT. must 12:00	

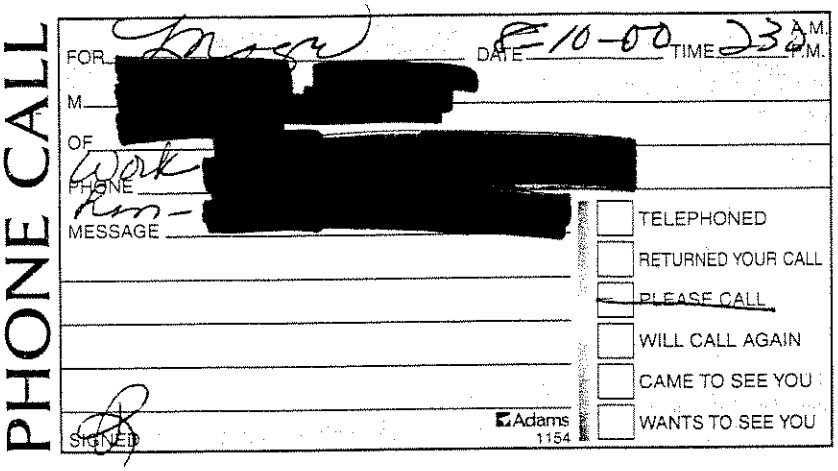
MESSAGE

SIGNED Sue

PHONED ☒ CALL BACK ☒ RETURNED CALL ☐ WANTS TO SEE YOU ☐ WILL CALL AGAIN ☐ WAS IN ☐ URGENT ☐

8/08/00 Didn't get a chance to call today. 1:30 pm

50600824



PHONE CALL

FOR [redacted] DATE 8-10-00 TIME 2:30 A.M. P.M.

M [redacted]

OF Work

PHONE [redacted]

MESSAGE Ran -

- [ ] TELEPHONED
- [ ] RETURNED YOUR CALL
- [ ] PLEASE CALL
- [ ] WILL CALL AGAIN
- [ ] CAME TO SEE YOU
- [ ] WANTS TO SEE YOU

SIGNED [redacted]

Adams 1154

8/11/00 10:45 I called [redacted] @ work # [redacted] (message went to "Hello you've reached the [redacted]")
"left message"

10:46 I call [redacted] @ home # [redacted] (message went from "Hello you've reached the home of [redacted]")
"left message"

50600825

PHONE CALL

FOR Mayor DATE 8-10-00 TIME 10 30 A.M. P.M.
M Edna Rose
OF
PHONE 505-683-6792 FAX
MESSAGE You indicated in a letter that you would call this Aug 8 —
SIGNED R.

- [ ] TELEPHONED
- [ ] RETURNED YOUR CALL
- [x] PLEASE CALL
- [ ] WILL CALL AGAIN
- [ ] CAME TO SEE YOU
- [ ] WANTS TO SEE YOU

Adams 1154

(8.11/00) 10⁵⁰/am & returned call. Left message.

PHONE CALL

FOR Mayor DATE Aug 11-00 TIME 1 30 A.M. P.M.
M Edna Rose
OF
PHONE 505-736-1926 FAX
MESSAGE "Sweeny Youth Homes" in Tampa
SIGNED R.

- [ ] TELEPHONED
- [ ] RETURNED YOUR CALL
- [ ] PLEASE CALL
- [ ] WILL CALL AGAIN
- [ ] CAME TO SEE YOU
- [ ] WANTS TO SEE YOU

Adams 1154

(8/11/00) 2³⁰pm & returned call – left message.

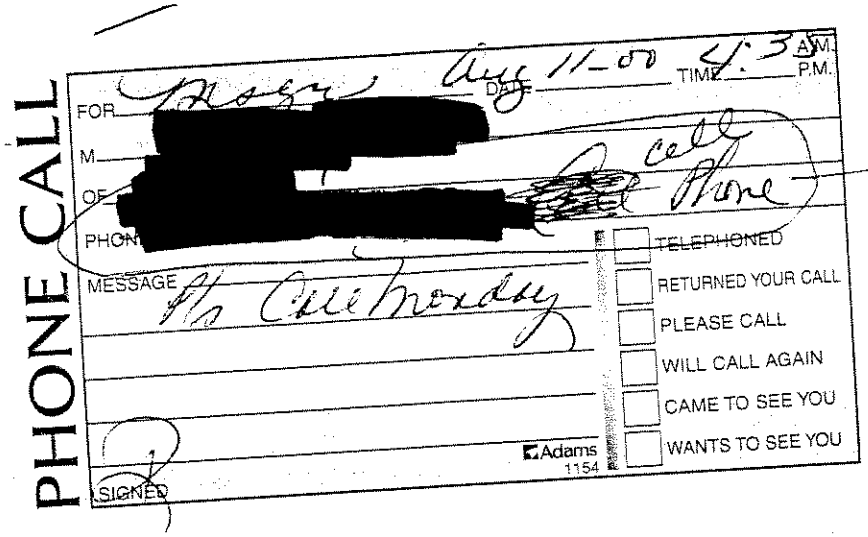
(8/14/00) 9⁰⁰am & returned call. ~~– left message.~~

(over)

50600826

→ Couple therapy is over
→ They are breaking up. ([redacted])
→ He will continue w/ Edna Moses.

I. Romas?



PHONE CALL

FOR [redacted]

DATE Aug 11-00 TIME 4:3 A.M. P.M.

M [redacted]

OF [redacted] cell Phone

PHONE

MESSAGE He Call Monday

- TELEPHONED
- RETURNED YOUR CALL
- PLEASE CALL
- WILL CALL AGAIN
- CAME TO SEE YOU
- WANTS TO SEE YOU

Adams 1154

SIGNED

→ use this #

9^00 am 8/14 I called - got busy signal.

10^00 am 8/14 I call [redacted] left message.

10^45 am 8/14 I called back. And spoke w/ [redacted]

- Wants to continue to counselling w/ Edna Moses even though he is moving to L.A.
- All is fine w/ him. He wants to continue w/ E. Moses.
- He appreciates the church's help in this.
- Call him on cell phone only.
- He might call in a few weeks to see if we can meet.

J Glueck

50600828

PHONE CALL

FOR Mags Hull DATE 12/1 TIME 10:40 A.M. P.M.

M. Edna [redacted] Moses

OF

PHONE FAX

MESSAGE Calling about [redacted] Will call again Monday.

SIGNED Alice

Adams 1154

- [X] TELEPHONED
- [ ] RETURNED YOUR CALL
- [ ] PLEASE CALL
- [X] WILL CALL AGAIN
- [ ] CAME TO SEE YOU
- [ ] WANTS TO SEE YOU

PHONE CALL

FOR Mags DATE Dec 7-00 TIME 2 12 A.M. P.M.

M. Edna Moses

OF

PHONE 225-663-6702 FAX

MESSAGE She said she called you on Friday & your didn't return & then called

SIGNED

Adams 1154

- [ ] TELEPHONED
- [ ] RETURNED YOUR CALL
- [X] ~~PLEASE~~ CALL
- [ ] WILL CALL AGAIN
- [ ] CAME TO SEE YOU
- [ ] WANTS TO SEE YOU

12-11-00 Edna will be billing you Billing & Status of Mental Health does not need you to call her - she is just keeping you informed periodically —

D

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JAN 5 2001

EDNA L.MOSES LCSW
5041 ROCOSO WAY
SANTA BARBARA, CA. 93111
(805) 683-6702
FAX (805)683-6702

January 1, 2001

Reverend Monsignor John Urell, V.G.
Vicar General / Moderator of the Curia
Diocese Of Orange

Dear Monsignor Urell:

Re: [redacted]

First, I would like to apologize for being late in keeping you up to date in regard to [redacted] progress in therapy. I will try to be more punctual in the future.
I see [redacted] once a week for an hour and forty minutes. Ideally, a patient who suffers from Post Traumatic Stress Disorder as a result of sexual abuse should be seen twice a week, However [redacted] moved to [redacted] therefore it is more practical to see him once a week in my Ventura office for an extended session.
The main target of my therapeutic intervention at the present time continues to focus on [redacted] total sense paralysis in dealing with issues that manifested in his relationship with his girlfriend. His paralysis and inability to assert himself were clearly a result of [redacted] deep sense of shame, inferiority and unresolved issues in regard to his sexuality, issues that are a direct result of his victimization by Father Ramos. [redacted] is making slow but steady progress. He has become more assertive, he is no longer paralyzed in his relationship with [redacted] the dynamic of his relationship with her has totally changed as [redacted] no longer allows her to emotionally abuse him. [redacted] has made a decision not to move in with [redacted] He wants to make more progress in therapy and be confident that the emotional abuse inflicted by [redacted] while they cohabitated in [redacted] will no longer be part of their relationship.
[redacted] sexual dysfunction persists and continues to cause [redacted] a great distress. Although I feel that it is time to focus my intervention on this symptom, [redacted] states he would like to continue with individual therapy and is not ready to include [redacted] in conjoint therapy, and as I mentioned before, [redacted] will have to participate in such therapy. Thus it seems that we will have to wait until [redacted] is ready to initiate this therapy. (My approach to treat sexual problems is behavioral therapy. I feel that is the shortest and the most helpful approach. Any other approach takes much longer and the result is less promising).
I hope that the church will continue to to understand that [redacted] problems caused by sexual molestation by Father Ramos are deep seated and require substantial intervention.

I have requested from Veronica A. Thomas Ph.D. a copy of the psychological evaluation of [redacted] She mailed summaries of two sessions but she could not find the requested evaluation. She wrote in October that she would try to look for this document, but I have not heard from her since then. I told her that you have a copy of this evaluation and she did not seem to have any problem that you share with me the documentation you have about this case. If you need a release of information signed by [redacted] I will be happy to mail or fax you one.
Should you have any further questions, feel free to contact me.

Sincerely,
Edna Moses
Edna L. Moses, LCSW