

INDEX CLINIC.

Investor proposal for Mitch. Prepared 2026-06-01.

THE ASK

Index Clinic is a physician-led peptide telehealth business, vertically integrated across doctor consults, third-party dispensing, Index Clinic Bloods pathology, and longitudinal patient care.

\$500,000 AUD FOR 15% EQUITY

Post-money	\$3,333,333
Phase 1 . Pre-launch	\$100,000
Phase 2 . Launch	\$150,000
Phase 3 . Growth	\$250,000

HEADLINE SCENARIOS (YEAR 1)

SCENARIO	REVENUE	EBITDA	NPAT	LOWEST CASH	BLENDED CAC
500 patients	\$610,651	\$-121,475	\$-121,475	\$215,284 (M7)	\$115
1,000 patients (base)	\$1,221,302	\$166,110	\$124,582	\$206,620 (M7)	\$167
4,000 patients	\$4,885,210	\$2,427,946	\$1,820,960	\$192,677 (M5)	\$236

All numbers pull directly from the working financial model. NPAT applies the 25% company tax accrued at M12 on positive Y1 profit. Lowest cash shown is the operating-cash trough before the \$500K is injected; with the raise applied at M1, lowest cash in the base case is \$208,380 (M7).

Phase 1 CAC of \$25/patient is what warm transfers from Canwell (~17,000 opted-in patients), Matter Agency (~3,000 influencers), and founder networks (~300 warm contacts) make possible. We have built these channels over years and they are the operator advantage. CAC scales up as we shift into broader paid acquisition in later phases.

BUSINESS MODEL

Physician-led peptide telehealth, vertically integrated across doctor consults, third-party dispensing, Index Clinic Bloods pathology, and longitudinal patient care. Doctors operate on revenue share (65/35), keeping clinical headcount variable. Index Clinic Australia Pty Ltd go-live is currently TBA, likely 1 July 2026.

UNIT ECONOMICS (PER PATIENT, 12-MONTH TENURE)

LINE	ANNUAL	LOGIC
Consults	\$437.50	5 visits at \$87.50 clinic share (gross \$250 x 35% post-doctor split)
Peptides	\$2,232.00	3 peptides, 12 dispenses/yr, \$62 margin per dispense (IWG Tier 3). In-house brand range is upside, not modelled.
Pathology	\$75.00	5 tests at \$15 via Index Clinic Bloods
TOTAL MARGIN PER PATIENT PER YEAR	\$2,744.50	

TENURE SENSITIVITY

The total above assumes 12 months of active treatment. In peptide telehealth, real-world tenure varies. We model three scenarios and headline the middle one.

SCENARIO	AVG TENURE	EFFECTIVE MARGIN PER PATIENT
Aggressive (A)	12 months	\$2,744
Base case (B, headline)	9 months	\$2,058
Conservative (C)	6 months	\$1,372

Retention levers documented in the model: longitudinal pathology cadence, in-house brand pipeline, clinical relationship continuity.

CUSTOMER ACQUISITION

Acquisition operates on a five-phase trigger framework. Each phase steps up when patient milestones land, not when months elapse. Phase 1 is anchored to warm transfers from the Canwell database and founder networks, which is what lets us hold \$25/patient at launch. CAC scales up materially as we move into broader paid acquisition.

PHASE	TRIGGER	CAC	PRIMARY CHANNELS
1	0 to 100 pts	\$25	Canwell warm transfers, founder networks, content
2	100 to 250 pts	\$75	Word-of-mouth from initial cohort, light paid tests
3	250 to 500 pts	\$150	Paid digital becoming significant
4	500 to 2,000 pts	\$200	Paid scaling, content, partnerships
5	2,000+ pts	\$275	Broader audiences, harder-to-reach segments

Sensitivity: if Phase 1 warm transfers underperform, CAC at launch moves toward \$100/patient (modelled separately in the workbook). Blended CAC across Y1 rises from \$115 to ~\$200 in the 500-patient scenario; the business still cash-flows by M11 at the 1,000-patient ramp.

BLENDED CAC ACROSS SCENARIOS

SCENARIO	NEW PATIENTS (Y1)	TOTAL CAC SPEND	BLENDED CAC
500 patients	500	\$57,500	\$115
1,000 patients (base)	1,000	\$167,250	\$167
4,000 patients	4,000	\$946,000	\$236

Why Phase 1 is \$25. Canwell (17,000 opted-in patients), Matter Agency (3,000 influencers), and founder networks (300 warm contacts) are the operator advantage. We are not entering cold. The model bakes those channels into Phase 1, and the upside is the speed at which we can move from warm transfers to scaled paid in Phases 3 and 4 once early cohort retention data lands.

USE OF FUNDS

CATEGORY	AMOUNT	%	NOTES
Operating burn to cash-positive	\$206,620	41%	Cumulative EBITDA deficit at peak trough. Of this, \$167,250 is CAC (the largest single line).
Legal / Compliance / AP applications	\$35,000	7%	Entity, T&Cs, contracts, HREC, supplier agreements
Working capital pre-fund	\$50,000	10%	Pathology + dispense stock + GST timing
Reserve / contingency	\$208,380	42%	Buffer for slower ramp, CAC overrun, unmodelled costs
TOTAL RAISE	\$500,000	100%	

Tranche release per original proposal: \$100K pre-launch, \$150K launch, \$250K growth.

COST BASE

Doctors on 65/35 revenue share, no fixed clinical payroll. Nurses hourly, scaling with consult volume. All four founders on salary from M1: Neil, Dave, Tom phase up from \$50K part-time to \$150K full-time at 500+ patients; Scott (Tech Lead) starts at \$100K and reaches \$150K at the same trigger. CX/Admin 2 staff from M1. Software capped at \$10K/mo. Non-wage opex ~\$15K/mo at steady state.

RETURN PATH

Index is built to be profitable from Y1 (positive NPAT in the 1,000- and 4,000-patient scenarios after 25% company tax). Founders are targeting strategic exit within ~3 years; in the meantime distribution mechanics are clean, and the business does not depend on a single liquidity event.

RISKS AND MITIGATIONS

- 1. Patient churn.** Longitudinal pathology cadence, in-house brand pipeline, clinical continuity.
- 2. CAC inflation.** Phase 1 anchored to durable warm channels rather than paid; paid spend ramps in lockstep with patient milestones. Model carries a sensitivity at \$100/pt Phase 1.
- 3. Regulatory shifts on peptides.** Compounding pathway, AP applications in progress, compliance bot infrastructure, prescriber relationships.
- 4. Clinical capacity.** Revenue share scales doctor supply with demand. Doctor-to-patient ratio modelled at 600:1 with 78% utilisation.
- 5. Dispense and pathology dependency.** Pre-negotiated IWG Tier 3 rates, multiple compounder relationships, in-house brand range in pipeline.