



*Dr. Brad Glowaki*

## THE INNATE CA AGREEMENT FORM

DC First/Last Name: \_\_\_\_\_

Office Name: \_\_\_\_\_

Office Address: \_\_\_\_\_ City: \_\_\_\_\_

ST: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

Office Phone: \_\_\_\_\_ DC Cell Phone: \_\_\_\_\_

DC Email Address for Access: \_\_\_\_\_

Team Email Address for Access: \_\_\_\_\_

By signing below, I agree to pay \$349 per month for the Level Up Mentoring Services and access to The Innate CA™ which such services include online training modules for the chiropractic industry as well as other online materials made available to clients under the Level Up Mentoring brand (the “Services”).

The Services shall be billed on the fifteenth of each month, with video training available on the twentieth of each month. Access to the Services shall be made available month-to-month, based on your advance payment for each month’s access. To cancel your subscription to the Service, you must notify New Patient Maven, Inc. in writing and online access shall terminate thirty days following such notice. All automatic payments occurring within such thirty-day period shall accrue to New Patient Maven, Inc. even through your access to the Services is terminating.

Name on Credit Card: \_\_\_\_\_

Credit Card #: \_\_\_\_\_

Exp. Date: \_\_\_\_\_ CVV#: \_\_\_\_\_ Billing Zip code: \_\_\_\_\_

Please note that by signing below, you are binding yourself, individually, to the Terms and Conditions set forth in Exhibit A (please request your copy) hereto and made a part hereof.

Accepted and agreed:

DC Printed Name \_\_\_\_\_ DC Signature \_\_\_\_\_

Date \_\_\_\_\_

CA’s Name: \_\_\_\_\_ CA’s Facebook Name: \_\_\_\_\_

1 \_\_\_\_\_ ☐

Team Leader

2 \_\_\_\_\_ ☐

3 \_\_\_\_\_ ☐

Level Up Mentoring  
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Seal Beach, CA 90740

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DB PP DC CA