Privately Funded Allied Health | Bloom Healthcare

Canonical: https://bloom-healthcare.com.au/services/private-allied-health/

Details:

Privately funded allied health means the person, their family, or another agreed payer covers the cost of the service. It is a direct pathway to clinical support where there is no NDIS plan or aged care funding in place, or where someone would rather not wait for one.

The thing worth being clear about from the start is this: private payment does not automatically create a Medicare or private health rebate. Whether a rebate exists depends on the discipline, the referral arrangement and your own cover. Ask about it specifically rather than assuming. To discuss an enquiry, call 1300 771 465 or email hello@bloom-healthcare.com.au .

When a private pathway makes sense

You do not have an NDIS plan , and you want to start now rather than after an access decision.

You are waiting for a plan, an aged care assessment or a funding decision and do not want to lose the time.

You want a specific assessment — a one-off opinion, a report, a functional review — rather than an ongoing service.

The need falls outside what a plan funds. Not everything someone wants help with is a funded support, and that is a legitimate reason to pay privately.

You are arranging support for a family member , with their consent.

You want to compare online and in-person options before committing to a pattern of appointments.

A private arrangement is also a reasonable way to find out whether a service helps before building it into a plan.

How the cost conversation should go

Start with the goal or the concern rather than trying to select the perfect discipline. Bloom can discuss suitable services, local availability and clinically appropriate delivery methods before you book.

Before anything is scheduled you should understand:

the agreed scope — what the service is intended to assess or support

the estimate for that scope, in writing

how travel is treated, because it is priced into in-home and community sessions

what a report costs if one is part of what you need, and how long it takes

the cancellation arrangement

whether telehealth would be clinically appropriate and what that changes

Rates, hours, travel and reporting are set out in a service agreement that is discussed and signed before service delivery and billing begin. Ask for it in writing and read it before you sign. The pricing page explains how each funding stream works, and the payments page covers invoicing and who receives it.

Referrals and rebates

Referral requirements and possible rebates depend on the discipline and the arrangement.

For psychology and counselling , Medicare rebates are available under a valid referral through the relevant initiative — see Medicare services . Without that referral, the service is simply a private one.

For most other allied health disciplines, you do not need a GP referral to make an enquiry, but a referral may be relevant to a rebate under your own private health cover. Check with your fund, because cover differs and nobody else can tell you what your policy pays.

Do not assume a rebate exists because a service is clinical. Ask the question, and ask it before the first appointment rather than after.

Choosing the setting

Where a privately funded session happens is a decision rather than a default, and it is worth making deliberately because it affects both usefulness and cost.

At home is the right choice when the environment is part of the problem: the bathroom, the steps, the kitchen, the chair that has become hard to get out of. It is also the right choice when getting out of the house is itself the difficulty.

In the community suits goals that are about a place — a shop, a station, a park path, a workplace. Practising the actual route beats practising a generic one.

By telehealth suits coaching, programme progression, planning and review, and removes the travel component of the fee. See telehealth for what it does and does not suit.

In a consulting room can be arranged case by case where that is what someone prefers, or where privacy at home is difficult.

Which disciplines are available privately

Occupational therapy for daily function, home safety, equipment and routines. Physiotherapy for movement, mobility and physical function. Speech pathology for communication and swallowing. Psychology and counselling for psychological wellbeing and participation. Exercise physiology for clinically appropriate exercise. Dietetics for nutrition. Positive behaviour support , and paediatric therapy for children and young people.

Clinical suitability, required expertise and availability are checked for each enquiry, and the agreed scope determines what is included.

How delivery works

The service is mobile: clinicians travel to your home, school, workplace, day program or another community setting, and telehealth is available where it is clinically appropriate. A therapy or consulting room can be arranged case by case where that suits you better.

Coverage by area is set out on the locations page . Availability differs by discipline as well as by area, so ask about the discipline you need at your postcode rather than about coverage in general.

What private funding does not change

Paying privately does not change the clinical standards, the documentation, the consent requirements or the service agreement. It does not entitle anyone to a service that is not clinically appropriate, and a clinician who thinks a different discipline or a different approach is indicated will say so regardless of who is paying.

It also does not remove the need for the right information. Existing reports, relevant history, current medications where they matter, and the goals that actually matter to the person all make the first appointment more productive.

Reports, and what they cost

A report is a separate piece of work from an appointment, with its own time and its own fee. If what you need is a report — for a school, an employer, an insurer, an NDIS access request or an aged care assessment — say so at the start, because it changes the assessment itself as well as the cost.

Ask what the report will cover, what it will not cover, how long it takes, and what happens if the person reading it comes back with further questions. A report written for one purpose is not always usable for another.

Deciding whether to keep going

After the first appointment you should have enough to decide whether to continue. The questions worth asking are whether the plan targets something you actually care about, whether progress will be visible to you and not only to the clinician, and roughly how many sessions the clinician expects before you would know whether it is working.

A clinician should be able to answer all three. If the honest answer is that it is too early to say, that is a legitimate answer, but it should come with a point at which it will be reviewed.

What happens next

Tell us your goal. The service need, the location and your preferred delivery method.

Check the clinical fit. Suitability, availability and any referral or medical information needed are confirmed.

Agree fees and scope. Appointment, report, travel and cancellation arrangements are clarified before booking.

Attend the first appointment , which is an assessment rather than treatment, and produces an action plan.

Review the next steps. Whether further sessions or other professional input are appropriate — including whether it is worth pursuing funded support instead.

If a funded pathway later becomes available, the work done privately is not wasted: existing assessments and reports are usually relevant to an NDIS or aged care application, and are worth keeping.

How to start

Call 1300 771 465 , email hello@bloom-healthcare.com.au , or use the referrals page . Anyone can refer: the person themselves, a parent or carer, a GP or paediatrician, a support coordinator, a plan manager, a school, a SIL provider, another health professional, or a nominee or guardian.

Useful information to include is the person's age, the main concerns, any existing reports or assessments, relevant history, the goals that matter to the family, and the best contact details.

A member of the team will be in contact within 24 hours of receiving a referral. The referral is then triaged and matched to a clinician on capacity, location, skill set and the specific need. A welcome pack and intake form follow, and nothing is scheduled until the intake form is completed and returned. Bloom aims to schedule the initial meeting within 5 business days where possible. Rates, hours, travel and reporting are set out in a service agreement that is discussed and signed before service delivery and billing begin.

If something is not working once services start, the feedback page explains how to raise it, the advocacy policy covers your right to an advocate, and the incident management policy sets out how incidents are handled and reported.

Can I contact Bloom Healthcare without having an NDIS plan?

Yes. You can enquire about privately funded services with Bloom Healthcare. Clinical suitability and availability are checked before acceptance.

Do I need a GP referral to access private allied health services at Bloom Healthcare?

It depends on the service and any intended rebate. Bloom Healthcare can explain the referral requirements for the proposed pathway. For most allied health disciplines a GP referral is not needed to make an enquiry, but a referral may be relevant to rebates under private health cover.

Can I claim private allied health services through my private health insurance?

That depends on your policy, the discipline, and clinician eligibility. You should confirm benefits with your insurer before booking.

Does paying privately for allied health automatically mean I can get a Medicare rebate?

No. A Medicare rebate is only available if the service, clinician, and referral meet the applicable Medicare requirements. Private payment alone does not establish eligibility for a rebate.

How much do privately funded allied health services cost at Bloom Healthcare?

Costs depend on the discipline, appointment length, delivery setting, and whether assessments, reports, or travel are included. You should ask Bloom Healthcare for the current fee and a written estimate before booking, and should not assume a Medicare or private health rebate will cover the cost.

Can privately funded allied health support be delivered at home or via telehealth?

You can ask about home visits, community appointments, and telehealth for your service postcode. Availability varies by discipline and location, and the clinician confirms whether the proposed setting or online delivery is suitable for the assessment or treatment needed.

When does privately funded allied health make sense instead of waiting for NDIS or aged care funding?

Private funding is appropriate when there is no NDIS plan in place and you want to start support now, when you are transitioning between programs or awaiting a funding decision, when you need a one-off assessment or report, when your need falls outside what a plan funds, when arranging support for a family member with their consent, or when you want to compare delivery options before committing.

Are Medicare rebates available for private psychology or counselling services?

For psychology and counselling, Medicare rebates are available under a valid referral through the relevant initiative. Without that referral, the service is simply a private one.

Who provides privately funded allied health services on this page, and what is their service area?

The service is provided by Bloom Healthcare, an allied health provider, and it is available across Australia.

How can someone enquire about privately funded allied health services with Bloom Healthcare?

Enquiries can be made through Bloom Healthcare's online contact channel, where clinical suitability and availability are checked before acceptance.